Capitol Comments LEGISLATIVE UPDATE

2019 Medicare Physician Fee Schedule Final Rule

The 2019 PFS Final Rule was published on November 1, 2018. Which is great because it gives us so much time to read through all 2,000+ pages and implement any necessary changes before the start of 2019. I guess you can say it's an early Christmas present from CMS.

But seriously, CCA pulled together a quick review of some of the major provisions in the rule. Major highlights include changes to E/M codes, but not until 2021, the removal of lots of measures for the MSSP program (!!!!), and the additions of a chronic care management code for RHCs and FQHCs (!!!!). So, not an entirely terrible present.

Other than that, it's mid-term election time. So, vote. If you haven't voted already, keep in mind that Texas allows American astronauts in space to electronically cast their ballots in federal elections. If they can do it, so can you.

Overview

The 2019 Medicare Physician Fee Schedule Final Rule was published on November 1st and includes the final changes to Medicare physician payment and quality measures for MSSP ACOs and QPP requirements for 2019. CMS created a fact sheet with high level details on the rule.

Physician Fee Schedule (PFS)

Physician Payment Update: The 2019 Medicare Physician Payment Schedule Conversion Factor is $36.0463. The Anesthesia conversion factor is $22.2986. The 2019 conversion factors reflect a statutory update of 0.25 percent, offset by a budget neutrality adjustment of -0.12 percent, resulting in a 0.13 percent update. This updated conversion factor includes the 0.5 percent increase mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

MSSP Quality Measure Changes: The Final Rule includes several changes to the MSSP quality measure set by removing 10 measures and adding 2 new measures. The Final Rule decreased the current 31 measures to 23 measures.

Measures Being Discontinued
ACO-35, Skilled Nursing Facility (SNF) 30-day Readmissions
ACO-36, All-Cause Unplanned Admissions, Diabetes
ACO-37, All-Cause Unplanned Admissions, Heart Failure
ACO-44, Use of Imaging Studies for Low Back Pain
ACO-12, Medication Reconciliation Post-Discharge
ACO-15, Pneumonia Vaccination Status for Older Adults
ACO-16, BMI Screening and Follow-Up
ACO-41, Diabetes Eye Exam
ACO-30, IVD Use of Aspirin or Another Antiplatelet
ACO-11, Use of Certified EHR Technology

New Measures
ACO-45, Courteous and Helpful Office Staff
ACO 46, Care Coordination

Evaluation and Management (E/M) Visits: CMS finalized a substantial update to E/M codes but pushed back implementation of the changes to 2021. CMS published a great one-pager outlining the changes in complexity levels for New Patient and Established Patient codes. The Proposed Rule was going to combine complexity levels 2-5 for both types of codes into single payment amounts. The Final Rule combines Levels 2-4 and maintains Level 5 for both types of codes (New Patient and Established Patient). Table below details the change briefly, the CMS one-pager provides much more detail on the change.

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NEW PATIENT CPT Code	Current (2018) Payment Amount	Revised Payment Amount Visit Code Alone Payment
99201	$45	$43
99202	$76	$130
99203	$110	
99204	$167	
99205	$211	$211

ESTABLISHED PATIENT CPT Code	Current (2018) Payment Amount	Revised Payment Amount Visit Code Alone Payment
99211	$22	$24
99212	$45	$90
99213	$74	
99214	$109	
99215	$148	$148

The Final Rule also allows practitioners to review and verify certain medical record information entered by ancillary staff or the patient, rather than re-entering the information.

Chronic Care Management (CCM) Services: For CY 2019, the CPT Editorial Panel created CPT code 99491, which describes situations when the billing practitioner is doing the care coordination work that is attributed to clinical staff in CPT code 99490. Beginning in 2019, CMS is adding this new 99491 code to the PFS, which would correspond to 30 minutes or more of CCM furnished by a physician or other qualified healthcare professional and is like CPT codes 99490 and 99487. For RHCs and FQHCs, it is added as a general care management service and is included in the calculation of G0511. Starting 1/1/19, RHCs and FQHCs will be paid for G0511 based on the average of the national non-facility PFS payment rates for CPT codes 99490, 99487, 99484, and 99491.

Payment for Care Management Services and Communication Technology-based Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS also created a new Virtual Communications G code for use by RHCs and FQHCs to bill for communication technology-based services or new remote evaluations services: G0071. This new G code could be billed alone or with other payable services, and at least 5 minutes of communication technology-based or remote evaluation services furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year. The medical discussion or remote evaluation cannot be for a condition related to an RHC or FQHC service provided within the previous 7 days, and it cannot lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

Quality Payment Program

The following table provides a comparison of performance category weights for MIPS-APM ACOs vs. MIPS Eligible Clinicians (ECs), as finalized for 2019:

Performance Category	ACOs (MIPS APM)		MIPS ECs	
	PY2018	PY2019 Finalized	PY2018	PY2019 Finalized
Quality	50%	50%	50%	45%
Cost	0%	0%	10%	15%
Improvement Activities (IA)	20%	20%	15%	15%
Promoting Interoperability (PI)	30%	30%	25%	25%

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The Final Rule increased the percent weight for the Cost category to 15% and decreases the percent weight for the Quality category to 45% for MIPS ECs. ACOs will continue to benefit from the MIPS APM scoring standard: the Quality category will remain at 50% and the Cost category will remain at 0%.

MIPS Performance Thresholds: CMS is increasing the MIPS performance threshold from 15 points (for 2018) to 30 points in 2019. This means everyone reporting MIPS must meet or exceed 30 points to receive a positive payment adjustment. The exceptional performance threshold is increasing from 70 points (for 2018) to 75 points in 2019. The exceptional performance bonus is available to those ECs that meet or exceed the exceptional performance threshold.

MIPS Eligible Clinicians (ECs) & Exclusions: CMS expanded the definition of MIPS ECs beginning in 2019 to include physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitian or nutrition professional.

MIPS EC Definition ***New additions for 2019**
Physicians
Physician Assistants
Nurse Practitioners
Clinical Nurse Specialists
Certified Registered Nurse Anesthetists
***Physical Therapists**
***Occupational Therapists**
***Qualified Speech-Language Pathologists**
***Clinical Psychologists**
***Registered Dietitian or Nutrition Professionals**

Low Volume Exclusion: CMS added a third criterion: providing fewer than 200 covered professional services to Part B FFS beneficiaries. The current low volume threshold exclusion includes two criteria for physicians to qualify:

1. Have billed $90,000 or less in PFS services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries.
2. Have 200 or fewer Medicare Part B FFS beneficiaries.

Quality: ACOs will continue to be exempt from any additional reporting requirements in MIPS. Currently, the MSSP ACO quality reporting requirements (i.e., GPRO) are used by CMS to determine the MIPS Quality score for MSSP ACOs. For ECs not participating in an ACO, the Quality score is decreasing to 45% in 2019 from 50% in 2018.

Bonus Points: ACOs currently receive some bonus points for reporting certain Web Interface measures categorized as “high priority” by MIPS. CMS has ended these bonus opportunities. The end-to-end electronic reporting bonus points will remain. ECs reporting individually or in a group are eligible to receive the end-to-end electronic reporting bonus points, if they meet the criteria.

Clinical Practice Improvement Activities (CPIA): No changes to how ACOs are evaluated in the Clinical Practice Improvement Activities category. MSSP ACOs will continue to receive an automatic 100% in this category for participating in the MSSP. For ECs reporting individually or as part of a group, the CPIA category will remain at 15%.

Promoting Interoperability (PI): The main point for the Promoting Interoperability category is the decision by CMS to not delay the requirement to move to 2015 CEHRT beginning in 2019. For ECs, everyone is now required to use 2015 CEHRT in 2019, and the PI Transition measure set will sunset at the end of 2018.

Performance-based Measurement: MIPS PI currently includes a base score, a performance score, and a bonus score as the three components of the total MIPS PI score for each ACO participant TIN. CMS is removing the base score and instead just including the performance score and bonus score components. This will change the performance score for each measure to increase to 40 points (most performance scores for each measure are currently 10 points).

Group Reporting & ACO Participants: Each ACO Participant TIN is currently required to report MIPS PI as a group. The Final Rule allows each ACO Participant TIN to report at either the individual or group level, starting PY2019.

Cost: No changes to ACOs being excluded from the Cost category. The MIPS APM scoring standard will continue to have the Cost category account for 0% of the final MIPS score for ACOs. For ECs reporting individually or as part of a group, the Cost category will increase from 10% (2018) to 15% (2019). CMS added 8 new episode-based measures to the Cost category. One important note on the Cost category: the Cost category percent score will not consider improvement until the 2024 MIPS payment year. This means points for improvement in this category won't take effect until 2024 (2022 Performance Year).

Final MIPS Score & Resulting Payment Adjustments: The MIPS 2019 Performance Year corresponds to 2021 payment adjustments. CMS estimates $372 million will be available in the budget-neutral pool for MIPS, which is in addition to the $500 million in the exceptional performance bonus payment pool for those that meet or exceed the 75-point exceptional performance threshold. This amount ($372 million) is an increase from 2018 due to the maximum penalty amount in PY2019 raising to 7% from 5% in PY2018.

This brief has also been posted on the Community Care Alliance's Member Portal: www.communitycarealliance.com/login

Marguerite Tuthill
Network Development Manager, Community Care Alliance
970.986.3677 or marguerite.tuthill@CommunityCareAlliance.com

Community Care Alliance