Summary: 2019 Medicare Physician Fee Schedule and Quality Payment Program Final Rule

On Nov. 1, 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) final rule, which will be published in the *Federal Register* on Nov. 23, 2018. This is the first year CMS combined the Medicare PFS and QPP rules. CMS published several fact sheets on the final rule including a fact sheet on the QPP changes and a fact sheet on the PFS changes for 2019.

One week later, CMS released a snapshot of physician performance during the first year of the QPP, 2017. These data indicate that 93% of clinicians who were MIPS-eligible in 2017 will get a positive MIPS incentive payment in 2019.

AMA is continuing to review the rule and will work with its colleagues in the Federation to further analyze these policies in the coming weeks. Below is a summary of the key policies included in the final regulation and the QPP performance results.

I. Physician Fee Schedule

Physician Payment Update

The 2019 PFS conversion factor is $36.0391. The Anesthesia conversion factor is $22.2730. The 2019 conversion factors reflect a statutory update of .25%, offset by a budget neutrality adjustment of -0.14%, resulting in a 0.11% update.

Evaluation and Management (E/M) Office Visits and Documentation Guidelines

In the 2019 proposed rule, CMS proposed revisions to the E/M documentation guidelines intended to reduce administrative burdens on physicians. In addition, CMS proposed coding and payment changes to new and established patient office visit services. The AMA led the development of a joint comment letter from 170 physician and other health professional organizations calling for CMS to finalize several proposed changes to E/M documentation guidelines for CY2019. The AMA is pleased that CMS is implementing the documentation policies which will significantly reduce administrative burdens and allow all physicians to spend more time with their patients. The AMA is also grateful that CMS has acknowledged the work of the AMA's CPT/RUC Workgroup on E/M and has postponed any coding and payment-related changes for E/M office visit services until CY2021. This delay in implementation will allow the CPT Editorial Panel to consider the Workgroup's proposal in February 2019, followed by prompt consideration by the AMA/Specialty Society RVS Update Committee (RUC).

On page 584 of the rule, CMS states:

> "We recognize that many commenters, including the AMA, the RUC, and specialties that participate as members in those committees, have stated intentions of the AMA and the CPT Editorial Panel to revisit coding for E/M office/outpatient services in the immediate future. We note that the 2-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders. We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes."

Removing Restrictions on E/M Coding
CMS finalized several changes to E/M documentation guidelines which were strongly supported by the AMA and other members of the Federation:

- The requirement to document medical necessity of furnishing visits in the home rather than office will be eliminated.
- 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 must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

These changes will take effect Jan. 1, 2019. CMS estimates that these changes will reduce clinician regulatory burdens associated with E/M documentation by $84 million in 2019.

The Original Proposal Condensing Office Visit Payment Amounts and Documentation Requirements
In the 2019 proposed rule, CMS proposed to implement single payment rates for new and established level 2 through level 5 office visits and to reduce documentation requirements for these collapsed payments to that of a level 2 CPT visit code. The agency proposed to continue to use the existing CPT structure for office visit codes 99201-99215, though it proposed to change CMS guidelines and only enforce certain aspects of the CPT structure by allowing physicians to choose the method of documentation, among the following options:

1. 1995 or 1997 Evaluation and Management Guidelines for history, physical exam and medical decision making (current framework for documentation)
2. Medical decision-making only
3. Physician time spent face-to-face with patients

CMS had also proposed an add-on code to each office visit performed for primary care purposes and an add-on code for specialties with inherently complex E/M visits, as well as a new prolonged service code to be used as an add-on to any office visits lasting more than 30 minutes beyond the underlying visit (i.e., hour-long visits in total).

CMS relayed that commenters overwhelmingly opposed the agency's proposed payment collapse. CMS will not finalize the proposal for CY 2019.

Other Coding/Payment Proposals Related to E/M
The following policies were also opposed by the AMA and will not be implemented by CMS:

- Payment reductions by 50% for office visits that occur on the same date as procedures (or a physician in the same group practice). The AMA brought attention to the fact that duplicative resources have already been removed from the underlying procedure through the current valuation process.
- In addition, CMS proposed to no longer allow podiatrists to report CPT codes 99201-99215 and instead would use two proposed G-codes for podiatry office visits.
- Condensed practice expense payment for the E/M office visits, by creating a new indirect practice expense category solely for office visits, overriding the current methodology for these services by treating Office E/M as a separate Medicare Designated Specialty. This change would also have resulted in the exclusion of the indirect practice costs for office visits when deriving every other specialty's indirect practice expense amount for all other services that they perform, which would

have resulted in large payment cuts for many specialties (i.e., a greater than 10% payment reduction for chemotherapy services).

Proposals for CY 2021 and the CPT/RUC Workgroup on E/M

For CY 2021, the agency conveyed its intention to implement the same payment rates for 99202-99204 and 99212-99214, leaving in place 99201/99211 and 99205/99215 distinct payment rates. In addition, CMS noted its intention to implement add-on codes for primary care services; inherently complex specialty E/M visits; and extended visits. These add-on codes would only apply to CPT codes 99202-99204 and 99212-99214. The AMA has modeled an estimate of the impacts to office visit payments (see attached). Please note that the AMA analysis focuses on payment redistribution within the office visits only, while the CMS analysis is based on impact to the specialty's total allowed charges. Of note, the implementation of the add-on codes would lead to an offset to the conversion factor or relative values of -2%.

CMS noted that it will also consider input from the AMA and the CPT/RUC Workgroup on E/M as well as input from across the medical community. In response to the Medicare PFS Proposed Rule, the Chairs of the AMA CPT Editorial Panel and the AMA/RUC formed the CPT/RUC Workgroup on E/M to:

- Capitalize on the CMS proposal and solicit suggestions and feedback on the best coding structure to foster burden reduction, while ensuring appropriate valuation.
- Consider a code change application to be submitted to the CPT Editorial Panel for consideration at its Feb. 7-9, 2019 meeting.

The Workgroup is comprised of 12 experts in both coding and valuation (6 members each from each of the CPT and RUC processes). In addition to the 12 Workgroup members, roughly 300 additional stakeholders from national medical specialty societies, CMS and other health care-related organizations have participated.

The Workgroup has expressed its appreciation of the agency's efforts to address longstanding issues with E/M services and has worked tirelessly over the past several months to establish a long-term, stable CPT coding solution. Listening to CMS and other stakeholder concerns, the Workgroup has worked to build consensus around modernizing the office and outpatient E/M CPT codes to simplify the documentation requirements and better focus code selection around medical decision-making and physician time. The Workgroup proposal will be formally reviewed by the national medical specialty societies via the CPT Advisory Committee process. The CPT Editorial Panel will review the proposal, and related comments, at the Feb. 7-9, 2019, meeting.

RUC Recommendations

CMS announced final work relative values for nearly 200 CPT codes reviewed by the RUC. CMS accepted 80% of the RUC recommendations and 87% of the RUC Health Care Professional Advisory Committee Review Board recommendations for CPT 2019. The AMA applauds CMS for accepting the RUC recommendations, such as for new CPT code 99491 for chronic care management personally delivered by a physician, which was based on survey data from more than 150 physicians, instead of using the flawed formulaic approach originally proposed. CMS did not consider the RUC recommendations for 20 X-ray services as formal surveys were not conducted by radiology and other specialties. CMS will maintain the 2018 values for 20 X-ray services instead of valuing them the same, regardless of anatomical area imaged or the number of views, as originally proposed. The RUC will work with specialty societies to conduct and review formal surveys for all 20 X-ray services for CY2020.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services
CMS is expanding access to medical care using telecommunications technology by finalizing coverage of several new services, including three new CMS-created HCPCS codes for: brief, non-face-to-face appointments via communications technology (virtual check-ins); evaluation of patient-submitted photos; and the foregoing codes bundled together for use by federally qualified health centers and rural health clinics. In addition, CMS finalized new CPT codes for Inter-professional Internet Consultation (CPT codes 99451, 99452), as well as unbundling and covering existing CPT codes 99446, 99447, 99448 and 99449. Also consistent with AMA advocacy, CMS finalized new CPT codes for Chronic Care Remote Physiologic Monitoring (99453, 99454 and 99457).

CMS finalized modifications to existing regulations required by the recent passage of the Bipartisan Budget Act of 2018 mandating expanded coverage of telehealth (two-way audio, visual real-time communication between physician and patient). CMS expanded coverage of telehealth services by modifying or removing limitations relating to geography and patient setting for certain services, including for end-stage renal disease home dialysis evaluation; diagnosis, evaluation, and treatment of an acute stroke; and services furnished by certain practitioners in certain accountable care organizations. CMS expanded telehealth coverage for prolonged preventive services (but coverage would still be subject to statutory geographic and originating site restrictions). The AMA strongly supports CMS' expansion of telehealth coverage.

Medicare Part B Drug Payments
CMS reduces reimbursements for new Part B drugs. Currently paid with an add-on payment of 6% (before sequester), CMS will reduce the add-on payment to 3% (before sequester) for all drugs with Wholesale Acquisition Cost (WAC)-based payment rates. Currently, only new drugs lacking Average Sales Price (ASP) data are paid based on WAC amounts, and usually only for part of the year. When drugs move to ASP-based payments, the add-on amount will return to 6%. ASP is usually determined after the first quarter the drug is on the market. The AMA opposed this proposal.

Clinical Laboratory Fee Schedule (CLFS)
CMS finalizes a revision to the "majority of Medicare revenues" threshold component of the new payment system applicable to tests paid on the CLFS. Under this new payment system, laboratories, including physician office-based laboratories, are required to participate in reporting to CMS private payer pricing data if they meet certain thresholds. One of those thresholds is that the laboratory must receive the majority of its Medicare revenues from payments on the PFS or CLFS. This final rule adjusts the previous component and moves to exclude payments made under Medicare Part C from the definition of "total Medicare revenues." CMS estimates that this will increase the opportunity for labs with large Part C revenues to participate in the reporting exercise, but states that it expects minimal impact on CLFS rates. The AMA in unsure of the impact it will have on the number of physician office-based laboratories that will have to report.

Appropriate Use Criteria
The AUC program requires ordering providers to consult with applicable Appropriate Use Criteria (AUC) through a qualified clinical decision-support mechanism for applicable imaging services. CMS previously delayed implementation of this program by including a voluntary reporting period, which started in July 2018 and runs through December 2019. In 2020, the AUC program period will begin with an educational and operations testing period, during which CMS will continue to pay claims whether or not they correctly include AUC information. The 2019 final rule:

- Expands the definition of an applicable setting to include independent diagnostic testing facilities;

- Creates significant hardship exceptions from the AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- Establishes the coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims;
- Allows non-physicians, under the direction of an ordering professional, to consult with AUC when the consultation is not performed personally by the ordering professional; and
- Clarifies that the AUC consultation information must be reported on all claims for an applicable imaging service (e.g., if separate, both the technical and professional claim must include the AUC information).

In its comments on the proposed rule, the AMA argued that physicians who successfully participate in either the APM or MIPS side of QPP should be exempt from the AUC program and called on CMS to extend the AUC testing period to two years.

Teaching Physician Documentation Requirements for E/M Services
CMS is revising federal regulations by allowing the presence of the teaching physician during E/M services to be demonstrated by notes in medical records made by a physician, resident, or nurse. CMS also revised federal regulations to provide that the medical record must document the extent of the teaching physician's participation in the review and direction of services furnished to each patient, and that the extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

Practice Expense Relative Values
Market-Based Supply and Equipment Pricing Update
As part of its authority under Section 220(a) of the Protecting Access to Medicare Act of 2014 (PAMA), CMS initiated a market research contract with a consulting firm, StrategyGen, to update the direct practice expense inputs for supply and equipment pricing for CY 2019. The AMA and other members of the Federation questioned the pricing of 62 supply and equipment items and submitted invoices and other supporting documentation for the pricing of these items. Based on the report from StrategyGen, CMS finalized updated pricing for 2,070 supply and equipment items currently used as direct practice expense inputs over a 4-year phase-in, with changes to the pricing for the 62 supply and equipment items flagged by stakeholders. Although the AMA agrees with CMS that there is a need for comprehensive review of supply and equipment pricing, we continue to have concerns about StrategyGen's use of subscription-based benchmark databases that are likely not representative of the typical price paid by small physician practices.

Professional Liability Insurance (PLI) Relative Values
CMS sought comment on ways to improve how specialties in the state-level raw rate filings data are cross-walked for categorization into CMS specialty codes to develop the specialty-level risk factors and the PLI RVUs. In a March 30, 2018, letter to CMS, the RUC offered its assistance to CMS to categorize rate filings and apply the specialty descriptions from the rate filings to the appropriate specialty codes. The RUC will continue to explore collaboration with CMS on this issue.

As recommended by the RUC and other commenters, CMS added approximately 30 codes to the low-volume services to the list of codes for anticipated specialty assignment.

In the Addendum for the CY 2019 Malpractice Risk Factors and Premium Amounts by Specialty, CMS continues to crosswalk non-MD/DO specialties to the lowest MD/DO risk factor specialty, Allergy

Immunology. The RUC has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician health care professions.

Global Surgery Data Collection
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement a process to collect data on postoperative visits and use these data to assess the accuracy of global surgical package valuation. Beginning July 1, 2017, CMS required groups with 10 or more practitioners in nine states to use the no-pay CPT code 99024 to report postoperative visits for specified procedures. Of practitioners that met the criteria for reporting, only 45% participated — this varied substantially by specialty. Among procedures performed by "robust reporters" of 99024, only 16% of 10-day global services and 87% of 90-day global services had one or more matched visits reported (volume-weighted). In the 2019 proposed rule, CMS solicited comments pertaining to increased compliance and whether visits are typically being performed in the 10-day global period. It also solicited comment on whether use of modifiers -54 "for surgical care only" and -55 "post-operative management only" should be mandated, regardless of whether the transfer of care is formalized. In the final rule, CMS noted that most commenters, including the RUC, said that more time was needed for data collection before drawing any conclusions. CMS plans to send another letter to eligible practitioners in the nine states to make them aware of the reporting requirement, as recommended by the RUC and other stakeholders. CMS also plans to continue to evaluate public comments received.

2019 Potentially Misvalued Codes List
Each year, CMS proposes a list of potentially misvalued codes for review by the RUC and possible adjustment. Since 2006, the RUC and CMS have identified 2,475 services through 20 different screening criteria for further review by the RUC. The RUC's efforts for 2009-2018 have resulted in $5 billion for redistribution within the PFS. CMS received public nominations identifying nine codes as potentially misvalued for review in future rulemaking, including seven codes nominated by Anthem. The RUC will review these services and submit recommendations for future rulemaking.

CPT Code	Short Descriptor
27130	Total hip arthroplasty
27447	Total knee arthroplasty
43239	EGD biopsy single/multiple
45385	Colonoscopy w/lesion removal
70450	CT head w/o contrast
93000	CT head w/o contrast
93306	TTE w/doppler complete

II. Quality Payment Program

General Issues

The AMA is pleased that CMS continues to promote policies which do not disadvantage and provide relief to physicians who see a small number of Medicare patients.

MIPS Expanded to New Clinician Types
CMS expands the MIPS-eligible clinician definition to new clinician types including physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals.

Low-Volume Threshold and Opt-In Policy
CMS adds a third criterion for physicians to qualify for the low-volume threshold–providing 200 or fewer covered professional services to Part B patients. CMS also adopts a new policy that allows physicians to opt-in to participate in MIPS or create virtual groups and receive corresponding payment bonuses or penalties if they meet or exceed one or two but not all the low-volume threshold elements (i.e., have less than or equal to $90,000 in Part B allowed charges for covered professional services, provide care to 200 or fewer beneficiaries, or provide 200 or fewer covered professional services under the PFS).

Performance Threshold
CMS sets the 2019 performance threshold for determining bonuses or penalties in 2021 at 30 points and the additional exceptional performance threshold at 75 points. CMS was previously required to raise the performance threshold from 15 points in 2018 to the overall performance mean or median in 2019. However, the Bipartisan Budget Act of 2018, which was strongly supported by the AMA, gave CMS the flexibility to gradually increase the performance threshold over the next three years. CMS found the mean final score in 2017 was 74.01 points and the median final score was 88.97 points.

Medicare Part B Drugs
As Congress required in the Bipartisan Budget Act of 2018, CMS finalizes its proposal to remove Part B drugs from the low-volume threshold determinations and from physicians' payment adjustments.

Special Status Determination Periods
CMS consolidates the determination periods to establish whether a physician meets or exceeds the low-volume threshold and qualifies for special statuses, including non-patient facing, small practice, hospital-based and ASC-based. The new consolidated determination periods run from Oct. 1, 2017 to Sept. 30, 2018 and from Oct. 1, 2018, to Sept. 30, 2019.

Virtual Groups
CMS makes very minor changes to its virtual group policies for the 2019 performance year. Physicians and groups can inquire about their group size prior to making a virtual group election between Oct. 1 and Dec. 31 of the calendar year prior to the applicable performance period. Group size inquiries can be made through the QPP Technical Assistance organizations.

Facility-Based Scoring Option
2019 is the first year physicians may be scored for purposes of the MIPS quality and cost performance categories based on their attributed hospital's performance in the Hospital Value-Based Purchasing Program. Facility-based scores for the 2019 performance period/2021 payment determination are based on the 12 measures included in the fiscal year 2020 Hospital VBP Program. There is no election or opt-in

required for facility-based scoring, nor is there an opt-out option. Instead, facility-based scoring automatically applies to MIPS eligible clinicians and groups who qualify and would benefit by having the facility-based score for their quality and cost performance. However, facility-based physicians have the option to participate through traditional MIPS and CMS will pick the best score to make a payment determination.

To qualify for facility-based scoring, physicians must perform 75 percent of their services in inpatient, on-campus outpatient or emergency room settings, and must have at least one service billed with the place of service (POS) code used for inpatient (21) or emergency room (23). To be scored as a group, 75 percent or more of the National Provider Identifiers (NPIs) billing under the group's Tax Identification Number (TIN) must be eligible for facility-based measurement as individuals, and the group must submit data in the Improvement Activity (IA) or Promoting Interoperability (PI) categories.

Accounting for Social and Clinical Risk Factors
CMS maintains the complex patient bonus of five points. The eligibility determination period for this bonus begins Oct. 1 of the calendar year preceding the applicable performance period and ends on Sept. 30 of the calendar year in which the performance period occurs, similar to the changes to the special status determination period.

Promoting Interoperability (PI) (previously Advancing Care Information): 25 percent of a physician's score

The AMA strongly supported a number of finalized changes to the PI category. This is one of the most significant overhauls of the federal government's EHR reporting program since its inception and is a solid step in the right direction.

For example, CMS has eliminated many burdensome and time-consuming measures that evaluate physicians on actions they cannot control—for example, patients viewing, downloading, or transmitting their medical records—which allows physician to spend more time on their patients instead of focusing on how to meet and report on arbitrary requirements.

Further, CMS has eliminated the base, performance and bonus scoring structure used in the first two years of MIPS and is instead scoring physicians on a 100-point scale at the individual measure level. CMS is also maintaining the hardship exceptions for this performance category.

2015 Certified Electronic Health Record Technology (CEHRT)
CMS requires all physicians to use 2015 CEHRT in 2019, which the AMA supports for purposes of increased patient access and advances in interoperability. Physicians who lack access to 2015 Edition CEHRT, e.g., their EHR vendor does not make 2015 Edition EHR available in time to meet the requirements of the PI performance category, will be able to request a hardship exception.

New Measures
CMS adds two new measures—scored as bonus points in 2019—to the e-Prescribing objective: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement. The Query of Prescription Drug Monitoring Program measure will remain a bonus through 2020, for which the AMA advocated. CMS has also consolidated two former measures into one new measure, Receive and Incorporate Health Information, but there is a new exclusion from this measure when a physician's EHR cannot receive or use electronic health information.

Reporting Period
Consistent with AMA advocacy, CMS is maintaining a consecutive 90-day reporting period in 2019.

Improvement Activities (IA): 15 percent of a physician's score

The AMA is very pleased that CMS is maintaining an attestation reporting option and a 90-day reporting period for the IA performance category; this has been a priority for AMA advocacy in this category. Advocacy has also successfully focused on maintaining reduced reporting requirements for small and rural practices. CMS is finalizing six new IAs, modifications to five existing IAs, and removal of one existing IA.

Bonuses in PI Category
Unfortunately, the previous bonus that physicians could receive in the ACI / PI category for completing certain IA activities has been removed. The AMA will continue to advocate for CMS to provide credit to physicians who use health information technology to complete IAs.

New IA Criterion
CMS adopts an additional criterion entitled "Include a public health emergency as determined by the Secretary" to the criteria for nominating new IAs to promote clinician adoption of best practices to combat public health emergencies such as the opioid epidemic. New IAs are not required to meet this criterion; rather, it is an additional option for stakeholders to utilize when submitting nominations for new IAs.

Quality: Now 45 percent of a physician's final score

Meaningful Measures Initiative
CMS is continuing its Meaningful Measures initiative and believes this will streamline reporting for physicians. Quality measure changes include adding 10 new quality measures, removing 26 measures immediately, and removing additional measures using a more gradual process provided in the CY 2018 final rule. As part of this effort, CMS finalized its proposal to revise the definition of a high-priority measure to include quality measures that relate to opioids and to further clarify the types of outcome measures that are considered high priority. CMS defines a high-priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure. The AMA is concerned about the large number of measures being removed absent a reduction in quality reporting requirements and the time needed to develop new measures, and will further analyze how this will affect physicians in different specialties.

New Reporting Option
CMS allows for a combination of data collection types for the quality performance category. CMS will score the measure based on the most successful collection type. The multiple-submission type option does not apply to web-interface reporters.

CMS limits the claims based reporting option to individuals who are in small practices. However, CMS expands the claims-based reporting option to allow small group practices (15 or fewer eligible clinicians) to report via claims.

Small Practices
CMS maintains the 3-point floor for quality measures that do not meet the data completeness requirement. In addition, CMS moves the small practice bonus points to a physician's quality category score, but

increases it to 6 points, as opposed to the proposed 3 points in 2019. The AMA will continue to advocate for the small practice bonus to apply to a physician's overall score. Limiting the bonus to the quality component ignores that small practices also need additional assistance in the other MIPS categories, particularly cost, to offset sample size reliability concerns, and increases the complexity of scoring.

Reporting Period
CMS maintains a full-year reporting period for the quality performance category in 2019, despite the AMA's advocacy to allow physicians and groups the option to submit a minimum of 90-days of data.

Score Re-weighting
CMS re-weights a physicians' score in the quality performance category if the score cannot be calculated due to lack of available measures, due to extreme and uncontrollable circumstances, or if an eligible clinician joined a practice in the last 90-days of a performance period and the practice does not participate as a group.

Data Completeness Criteria, Threshold and Scoring
CMS maintains that for a physician to be successful in reporting on a measure, they must meet the data completeness criteria of 60% of all denominator eligible patients, and must report a minimum of 20 cases. Physicians reporting via claims must report on 60% of Medicare Part B patients only and on a minimum of 20 cases.

For groups registered to report the CAHPS for MIPS survey, CMS finalizes an additional policy. If the survey sample size is not sufficient, the total available measure achievement points (the denominator) would be reduced by 10 points and the measure would receive zero points.

If a measure has a benchmark and a physician meets the data completeness criteria, they are eligible to receive 3-10 points based on performance compared to the benchmark. If a physician fails to meet the data completeness criteria, they are only eligible to receive 1 point. Small practices would continue to receive 3 points if they do not meet the data completeness criteria.

Topped Out Measures
Despite the AMA's strong objection, CMS finalizes the definition and lifecycle for topped out measures, the definition and lifecycle for extremely topped out status, and excludes QCDR measures from the topped-out process.

For the 2020 payment year, 6 measures receive a maximum of 7 measure achievement points, provided that the applicable measure benchmarks are identified as topped out again in the benchmarks published for the 2018 performance period. Beginning with the 2021 MIPS payment year, measure benchmarks (except for Web Interface) that are identified as topped out for two or more consecutive years receive a maximum of 7 measure achievement points beginning in the second year the measure is identified as topped out.

Measures Impacted by Clinical Guideline Changes
Measures impacted by clinical guideline changes will be given a score of zero, and the physician who reports the measure will have his or her quality performance category denominator score reduced by 10. The AMA was supportive of this proposal as it recognizes changes in scientific evidence and does not penalize physicians mid-reporting period for guideline changes.

Bonus Points

- High-Priority Measures: For the 2019 performance year, as supported by the AMA, CMS discontinues awarding bonus points to CMS Web Interface reporters for reporting high-priority measures, but would continue the high priority bonus (as long as a physician reports on a minimum of one high-priority measure) for all other reporting types.
- End-to-end Reporting: CMS continues to assign bonus points for end-to-end reporting for the 2021 payment year as a way to incentivize reporting through electronic means.

Improvement Scoring

Despite the AMA's objection, CMS continues to measure improvement in Year 3. In order to receive improvement points, eligible clinicians must fully participate (i.e. submit all required measures and have met data completeness criteria for the performance year). However, the quality improvement percent score is zero if the eligible clinician did not fully participate in the quality category for the current performance period. Therefore, improvement scoring cannot reduce a clinician's quality category score, but only add to the overall quality score. The AMA believes it is premature to begin measuring improvement due to the lack of access to timely data and experience physicians have with participating in MIPS and the large number of measures CMS removed from the program.

Future Approaches to Scoring the Quality Performance Category

CMS sought comment on several approaches to scoring quality in the future as an effort to move physicians toward reporting high-value measures and more accurate performance measurement. The AMA voiced some initial concerns with the proposals because they appear to add complexity to the program as opposed to simplifying scoring and reducing physician burden. CMS has taken the AMA's comments into consideration and will consider for future rulemaking.

Cost: Now 15 percent of a physician's final score

Cost Category Weight

Ten percent of physicians' MIPS score is tied to costs in 2018. This was originally scheduled to rise to 30% in the 2019 performance year; however, the Bipartisan Budget Act of 2018 authorized CMS to weight costs at any level from 10% to 30% through the next three years. CMS proposed to increase the cost weight to 15% in 2019 and noted it "anticipates" increasing the weight by an additional 5% in each of the next two performance years until it reaches the maximum 30% in the 2022 performance year.

Despite protests from the AMA and many other medical organizations, CMS increases the cost category weight to 15% and maintains all the key provisions in the proposed rule, including several that are intended to increase the number of physicians who will have cost measures attributed to them. The AMA had maintained that in its eagerness to expand the impact of this category, CMS was proposing a number of policies that would compromise the integrity of the cost measures and reward or penalize physicians unfairly.

Cost Measures

As previously proposed, the final rule retains the two existing cost measures (Medicare Spending Per Beneficiary and Total Per Capita Cost of Care) with no changes and adds 8 new episode-based measures in 2019. All the measures include both Part A and Part B costs and are calculated from administrative claims. CMS intends to continue setting a relatively low 0.4% reliability threshold for all the cost measures in order to "measure as many clinicians as possible in the cost performance category."

Unlike the current measures, which had no real clinical input, the new episode measures were developed with significant input from clinicians. They have undergone a limited pilot test in which most, but not all, exceeded the 0.4% reliability threshold. Five of the new measures are tied to costs associated with a particular procedure (elective percutaneous coronary intervention, knee arthroplasty, revascularization for lower limb ischemia, routine cataract removal with IOL, and screening colonoscopy). Three (intracranial hemorrhage or cerebral infarction, simple pneumonia with hospitalization and ST-Elevation Myocardial Infarction with PCI) involve costs associated with an acute inpatient medical condition. Reliability was generally higher for the procedural than the medical measures.

Procedural episodes are attributed to any physician who billed one of the trigger procedure codes, and any physician with at least 10 episodes in a given measure is scored on it. For medical condition measures, CMS attributes episodes to each physician who bills for inpatient E/M services and is affiliated with a group (TIN) that provides at least 30% of inpatient E/M codes during a hospitalization for the condition in question. To have the measure counted in the cost score, the TIN needs a minimum of 20 cases. Earlier versions of the measure were attributed at the individual level rather than the TIN level unless the physicians participated as a group. The modification is intended to make more physicians subject to the cost category.

The AMA believes that well-designed episode-based measures are potentially more fair and accurate than the MSPB and TPCC and has been very supportive of the process that CMS and its contractor (Acumen) have used to develop the eight new measures. However, because the eight new measures were subjected only to a limited pilot, the modified attribution methodology was not tested, at least one measure is not sufficiently reliable, and the vast majority of physicians are not familiar with the new measures, the AMA had argued that the cost category weight should stay at 10% in 2019.

Alternative Payment Models (APMs)

The AMA is pleased that CMS agreed not to increase the financial risk requirement for APMs for at least the next six years. We also appreciate that the agency is engaging with stakeholders that have submitted proposals for physician-focused APMs to leverage their experiences in the field.

Consistent with AMA recommendations not to require that APMs take increased financial risk in order to qualify as Advanced APMs, CMS is maintaining the revenue-based financial risk requirement for Advanced APMs at 8% of revenues through 2024.

Consistent with AMA advocacy, CMS allows Other Payer APMs to describe their compliance with requirements that APM physicians use CEHRT instead of mandating inclusion of this information in payment contracts.

As AMA recommended, CMS is permitting Other Payer APMs to be certified as meeting CMS APM requirements for up to 5 years instead of having to annually re-apply.

Physicians are now able to establish that they meet the All-Payer threshold for Qualified APM Participants at the practice level in addition to individuals and APM entities.

CMS clarifies that APM participants can meet required Medicare and Other Payer participation thresholds using a mix of patient counts and payment counts, whatever is most advantageous to the physician.

In response to AMA advocacy aimed at helping physicians who practice in areas with an above-average proportion of Medicare patients in Medicare Advantage (MA) plans, MIPS reporting and payment adjustments are waived for physicians participating in MA APMs, effective in 2018.

Beginning in 2019 for Medicare APMs and 2020 for Other Payer APMs, the percentage of an APM's participating physicians required to use CEHRT increases from 50% to 75%.

Estimated 2019 QPP Impacts

Estimated impacts in the 2019 proposed rule were based on reporting under the legacy programs that predated MIPS, but the final rule has updated its estimates for the 2019 QPP performance year and 2021 MIPS payment adjustments to reflect actual experience during the first MIPS performance year. CMS now estimates that 797,990 clinicians will be MIPS eligible in 2019, compared to 650,165 in the proposed rule. It has also significantly decreased its estimate of number of clinicians that will not be eligible for MIPS in 2019 due to various exclusions to 677,262, compared to 872,816 in the proposed rule.

Based on the very high percentage of MIPS eligible clinicians in 2017 who participated in MIPS that year, CMS projects that 97.8% of MIPS eligible clinicians will submit performance data in 2019. Of those submitting data, 91.2% are projected to receive a positive or neutral payment adjustment in 2021, with the remaining 8.8% receiving a penalty in 2021. Nearly two-thirds of those projected to receive a positive or neutral payment adjustment are projected to score high enough for an "exceptional" payment adjustment.

2017 QPP results

CMS separately released data about physician participation results in the first year of MIPS. As a result of the 2017 transition year for MIPS with its "pick your pace" option, 93% of MIPS eligible clinicians will receive a positive incentive payment in 2019 and 95% will avoid a penalty. Of the 93% receiving a positive incentive, 71% earned an additional bonus for exceptional performance by scoring between 70-100 points in MIPS. In addition, nearly 100,000 physicians earned a 5% lump sum bonus payment in 2019 by participating in Advanced APMs.

It is clear CMS' transitional implementation of the new MIPS program with a reasonable on-ramp allowed for broad physician success across practice size, type, specialty and location. The mean score for MIPS eligible clinicians was 74.01 points, clinicians in rural practices earned a mean score of 63.08 points, and clinicians in small practices received a mean score of 43.46 points. These mean scores are actually high enough to avoid a penalty or earn a positive incentive payment for the 2017, 2018, and 2019 performance periods.

III. Other Issues

CMS added several policies to this rule that were not addressed in this proposed rule.

- Medicare Shared Savings Program: CMS issued a proposed rule outlining significant policy changes for Medicare accountable care organizations (ACOs) for which comments were due in Oct. 2018. To provide a measure of stability and predictability for ACOs, in this final rule CMS is finalizing a voluntary 6-month extension for existing ACOs whose participation agreements expire at the end of 2018, and a methodology for determining financial and quality performance for the 6-month performance period from January–June 2019.

- Substance Use Treatment: Based on a provision in the recently enacted Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that was strongly supported by the AMA, CMS is removing the originating site geographic requirements and adding the patient's home as a permissible originating site for telehealth services furnished to treat substance use disorders or co-occurring mental health disorders, effective on or after July 1, 2019.

Estimated Impact of CY2021 Office E/M Payment Collapse

Includes CPT Codes 99201-99215
Analysis uses CY2017 Medicare Utilization and CY2019 Final Medicare CF and RVUs for both CY2019 and CY2021 Estimates
Excludes specialties with less than $1 million in CY2017 allowed charges for 99201-99215 or claims with unknown specialty designation; note, the following depicts a more granular specialty representation than tables 24C/95 in the CY2019 MPFS Final rule

Medicare Designated Specialty	Total Estimated Medicare Payment for Office Visits for CY2019	Total Estimated Medicare Payment for Office Visits Collapsing Level 2-4 Only (CY2021)	Percent Change in Office Visit Payment (Collapsing Payment for Levels 2-4 Only)	Add-on G Codes Medicare Payment Estimate (GPC1X and GCG0X)	Approximate Impact of -2.4 Percent Conversion Factor/ RVU Adjustment to Offset GPC1X and GCG0X
TOTAL	$ 23,459,535,194			$ 2,278,650,777	$ (2,290,124,554)
ADDICTION MEDICINE	$ 4,680,886	$ 4,596,012	-2%		$ (222,894)
ALLERGY/IMMUNOLOGY	$ 96,414,642	$ 95,542,484	-1%	$ 12,704,060	$ (6,083,603)
ANESTHESIOLOGY	$ 170,551,425	$ 169,023,146	-1%		$ (50,118,238)
CARDIAC ELECTROPHYSIOLOGY	$ 124,148,218	$ 115,611,189	-7%		$ (14,318,223)
CARDIAC SURGERY	$ 23,295,582	$ 23,285,500	0%		$ (7,131,789)
CARDIOLOGY	$ 1,683,175,918	$ 1,539,957,598	-9%	$ 202,033,721	$ (132,979,742)
CERTIFIED CLINICAL NURSE SPECIALIST	$ 34,711,016	$ 34,078,872	-2%		$ (1,776,628)
CERTIFIED NURSE MIDWIFE	$ 2,542,267	$ 2,869,682	13%		$ (132,081)
CERTIFIED REGISTERED NURSE ANESTHETIST	$ 1,212,846	$ 1,185,069	-2%		$ (28,696,861)
COLORECTAL SURGERY (PROCTOLOGY)	$ 32,744,893	$ 35,471,863	8%		$ (4,067,461)
CRITICAL CARE (INTENSIVISTS)	$ 36,134,578	$ 33,467,605	-7%		$ (8,453,489)
DERMATOLOGY	$ 892,877,725	$ 1,069,421,380	20%		$ (89,324,392)
DIAGNOSTIC RADIOLOGY	$ 12,295,073	$ 13,454,446	9%		$ (124,260,075)
EMERGENCY MEDICINE	$ 165,640,879	$ 165,007,154	0%		$ (76,776,615)
ENDOCRINOLOGY	$ 376,157,895	$ 337,698,043	-10%	$ 43,540,306	$ (12,357,319)
FAMILY MEDICINE	$ 3,634,810,233	$ 3,518,168,727	-3%	$ 508,582,405	$ (157,968,190)
GASTROENTEROLOGY	$ 496,814,262	$ 488,459,983	-2%		$ (41,174,302)
GENERAL PRACTICE	$ 182,814,456	$ 185,797,356	2%	$ 25,788,414	$ (9,798,420)
GENERAL SURGERY	$ 332,581,560	$ 361,584,549	9%		$ (48,984,000)
GERIATRIC MEDICINE	$ 62,903,100	$ 58,134,025	-8%	$ 7,449,852	$ (4,742,957)
GERIATRIC PSYCHIATRY	$ 5,203,311	$ 5,191,737	0%		$ (470,288)
GYNECOLOGICAL ONCOLOGY	$ 28,912,978	$ 27,869,838	-4%		$ (1,417,699)
HAND SURGERY	$ 62,337,124	$ 70,968,047	14%		$ (5,286,793)
HEMATOLOGY	$ 35,900,886	$ 33,518,662	-7%		$ (1,711,939)
HEMATOLOGY/ONCOLOGY	$ 700,349,990	$ 661,933,927	-5%	$ 81,211,928	$ (38,180,367)
HOSPICE AND PALLIATIVE MEDICINE	$ 6,495,913	$ 6,194,451	-5%	$ 583,646	$ (983,571)
INFECTIOUS DISEASE	$ 87,352,895	$ 84,159,088	-4%	$ 10,830,063	$ (15,853,812)
INTERNAL MEDICINE	$ 3,900,244,206	$ 3,741,274,335	-4%	$ 523,592,121	$ (264,031,332)
INTERVENTIONAL CARDIOLOGY	$ 232,144,948	$ 211,624,802	-9%		$ (22,019,994)
INTERVENTIONAL PAIN MANAGEMENT	$ 169,422,386	$ 165,425,835	-2%	$ 23,474,448	$ (10,834,154)
INTERVENTIONAL RADIOLOGY	$ 9,530,144	$ 10,109,688	6%		$ (9,508,396)
MAXILLOFACIAL SURGERY	$ 4,585,779	$ 5,543,234	21%		$ (449,459)
MEDICAL ONCOLOGY	$ 217,787,525	$ 205,569,022	-6%		$ (11,720,083)
NEPHROLOGY	$ 367,949,958	$ 335,948,629	-9%	$ 41,786,439	$ (53,118,229)
NEUROLOGY	$ 672,663,831	$ 624,593,663	-7%	$ 65,034,030	$ (37,059,286)
NEUROPSYCHIATRY	$ 3,355,882	$ 3,159,917	-6%		$ (254,023)
NEUROSURGERY	$ 116,673,304	$ 120,963,053	4%		$ (19,314,889)
NUCLEAR MEDICINE	$ 3,277,069	$ 3,021,782	-8%		$ (2,551,392)
NURSE PRACTITIONER	$ 1,450,774,818	$ 1,458,674,768	1%	$ 213,587,271	$ (83,981,278)
OBSTETRICS/GYNECOLOGY	$ 226,871,578	$ 240,247,403	6%	$ 32,275,120	$ (13,775,207)
OPHTHALMOLOGY	$ 518,602,849	$ 518,227,282	0%		$ (134,452,525)
OPTOMETRY	$ 275,518,842	$ 295,215,836	7%		$ (30,981,063)
ORAL SURGERY	$ 8,560,373	$ 9,449,205	10%		$ (1,354,414)
ORTHOPEDIC SURGERY	$ 954,634,897	$ 1,052,774,904	10%		$ (91,803,186)
OSTEOPATHIC MANIPULATIVE MEDICINE	$ 20,655,982	$ 21,319,269	3%		$ (1,210,579)
OTOLARYNGOLOGY	$ 486,686,537	$ 524,576,786	8%	$ 70,462,635	$ (30,892,502)
PAIN MANAGEMENT	$ 167,851,133	$ 163,668,972	-2%		$ (10,476,401)
PATHOLOGY	$ 2,904,658	$ 3,217,016	11%		$ (30,736,363)
PEDIATRIC MEDICINE	$ 26,010,167	$ 25,481,388	-2%	$ 3,424,718	$ (1,539,183)
PERIPERAL VASCULAR DISEASE	$ 3,046,506	$ 3,047,579	0%		$ (539,482)
PHYSICAL MEDICINE AND REHABILITATION	$ 298,501,886	$ 293,289,946	-2%		$ (26,955,697)
PHYSICIANS ASSISTANT	$ 887,409,454	$ 928,581,426	5%	$ 134,172,254	$ (51,427,720)
PLASTIC AND RECONSTRUCTIVE SURGERY	$ 55,840,493	$ 65,682,818	18%		$ (9,141,277)
PODIATRY	$ 652,741,065	$ 839,440,692	29%		$ (52,017,080)
PREVENTIVE MEDICINE	$ 6,400,090	$ 6,570,719	3%		$ (393,158)
PSYCHIATRY	$ 432,127,985	$ 447,068,242	3%	$ 65,908,862	$ (28,365,585)
PULMONARY DISEASE	$ 521,958,705	$ 485,431,584	-7%	$ 60,186,839	$ (41,518,447)
RADIATION ONCOLOGY	$ 85,133,897	$ 87,119,406	2%		$ (43,734,805)
RHEUMATOLOGY	$ 377,456,606	$ 347,213,918	-8%	$ 46,314,201	$ (13,510,736)
SLEEP MEDICINE	$ 18,852,333	$ 17,595,979	-7%		$ (1,052,079)
SPORTS MEDICINE	$ 42,412,070	$ 45,034,489	6%		$ (2,449,196)
SURGICAL ONCOLOGY	$ 18,817,246	$ 19,355,856	3%		$ (2,059,241)
THORACIC SURGERY	$ 34,472,091	$ 34,948,564	1%		$ (8,616,497)
UROLOGY	$ 757,728,799	$ 767,862,404	1%	$ 105,707,445	$ (44,654,260)
VASCULAR SURGERY	$ 116,581,199	$ 126,307,034	8%		$ (27,644,647)