spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

CY 2019 Physician Fee Schedule and Quality Payment Program Final Rule

OVERVIEW

On November 1st, the Centers for Medicare and Medicaid Services (CMS) finalized the 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) rule. In addition to updating the PFS and QPP for 2019, the rule will: implement provisions of the Bipartisan Budget Act (BBA) of 2018, update Evaluation and Management (E/M) billing practices, finalize changes to the Medicare Shared Savings Program (MSSP), expand telehealth, change the payment methodology for new Part B drugs, establish a new benefit category for opioid treatment programs, and update non-physician scope of practice and billing requirements.

The final rule is available here.

PFS PROVISIONS

The PFS sets physician payment rates by establishing relative value units (RVUs) and converting them into rates through a conversion factor. The rule finalized a 2019 PFS conversion factor of $36.04, a slight increase above the 2018 conversion factor of $35.99.

E/M Visit Payments

To justify Medicare payment for E/M visits, CMS requires that providers follow guidelines established in the 1990s to document patient history, medical examination, and clinical decision making. The final rule will implement a number of changes affecting the documentation, coding, and payment of E/M visits over the next few years. Beginning in 2019, CMS will:

- Eliminate the documentation requirement for the medical necessity of a home visit that occurs in lieu of an office visit;
- Ease reporting requirements for established patients by allowing providers to only report on how the patient's condition has changed, as opposed to re-documenting all information;
- Allow providers to verify the chief complaint and patient history in the medical record that has been entered by ancillary staff or the beneficiary without having to re-enter it; and
- No longer require that teaching physicians enter notations into medical records that have already been reported by residents or other members of the care team.

There are currently five different payment rates (levels 1 through 5) for E/M office/outpatient visits. In the proposed rule, CMS outlined its plan to establish a single blended payment rate for E/M office/outpatient levels 2 through 5 visit codes. In response to stakeholder feedback, CMS will instead establish a single rate for E/M levels 2 through 4 visit codes and maintain the payment rate for E/M level 5 visits, beginning in 2021. In addition to the new rate, providers will be able to report add-on codes for E/M office/outpatient level 2 through 4 visits when:

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Additional resources are necessary for primary care or specific types of non-procedural specialized medical care; and
- Providers need to spend extended time with the patient.

The rule will also allow providers to document E/M office/outpatient level 2 through 5 visits using medical decision-making (MDM) or time, in addition to the current documentation framework, in 2021. If providers are reporting a level 2 through 4 visit using MDM or the current framework, CMS will apply a minimum supporting documentation standard for reporting history, exam, and/or medical decision making. If providers are using time to report the visit, the provider will have to document the medical necessity of the visit and verify that the billing practitioner spent the required amount of face-to-face time with the beneficiary.

After considering stakeholder feedback, CMS will not finalize its proposal to standardize the allocation of Practice Expense (PE) RVUs for the codes that describe E/M services. Practice expenses (PEs) cover general categories of direct and indirect expenses, such as medical supplies and administrative labor.

MSSP Accountable Care Organizations (ACOs)

Earlier this year, CMS issued a proposed rule that would discontinue or replace all MSSP Tracks (1, 1+, 2, and 3) and implement two new tracks, BASIC and ENHANCED, in 2019. The PFS rule finalizes that the first BASIC and ENHANCED Track agreement period would begin on July 1, 2019. To accommodate existing MSSP ACOs with participation agreements scheduled to end on December 31, 2019, there will be a six-month extension period so that they may enter a new BASIC or ENHANCED Track on July 1.

Other MSSP provisions of the PFS final rule include:

- Allowing beneficiaries who voluntarily align to a Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO that their provider is participating in even if there are no associated claims; and
- Revising the definition of primary care services used in beneficiary assignment to include codes for advance care planning, administration of health risk assessment, prolonged evaluation and management, psychotherapy services, annual depression screenings, alcohol misuse screenings, and alcohol misuse counseling services.

Telehealth Expansion

Medicare fee-for-service (FFS) has historically imposed extensive restrictions on telehealth services reimbursement. Currently, access to telehealth is generally limited to rural areas and regions designated as health professional shortage areas, with exceptions for certain providers at financial risk for the cost of care. The rule includes a number of provisions that will expand access to Medicare telehealth benefits, such as:

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

- Adding codes (HCPCS codes G0513 and G0514) for prolonged preventive services to the list of telehealth services;
- Adding renal dialysis facilities and the homes of end-stage renal disease (ESRD) beneficiaries as originating sites for dialysis and not applying the originating site geographic requirement for furnishing home dialysis monthly ESRD-related clinical assessments from hospital-based renal dialysis centers, renal dialysis facilities, and beneficiaries homes;
- Adding mobile stroke units as originating sites and not applying geographic requirements for services delivered to diagnose, evaluate, or treat symptoms of acute stroke;
- Removing originating site geographic requirements and adding the home of the beneficiary as an allowable originating site for substance use disorder or co-occurring mental health disorder services; and
- Paying separately for the following communication technology-based services without being designated as "telehealth services" or subject to geographic restrictions on the originating site:
    - Brief Communication Technology-based Service, e.g.- Virtual Check-in (HCPCS code G2012);
    - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code G2010);
    - Chronic care remote physiologic monitoring (CPT codes - 99453, 99454, and 99457); and
    - Interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

Off-Campus Provider-Based Hospital Departments

Prior to January 1, 2017, certain items and services that were rendered by off-campus provider-based departments of a hospital were covered under the Hospital Outpatient Prospective Payment System (OPPS). Beginning in 2017, CMS established the PFS as the applicable payment system for the delivery of nonexempted items and services using a PFS Relativity Adjuster. The final rule will maintain the PFS Relativity Adjuster at 40%, meaning that under the applicable payment system, nonexempted services will be paid 40% of the amount that they would be paid under the HOPPS.

New Part B Drug Payments

Most Part B drugs are paid based on a methodology using the Average Sales Price (ASP), but new Part B drugs that do not have a sufficient amount of sales price data to calculate an ASP are currently paid based on the Wholesale Acquisition Cost (WAC) with an add-on payment of 6%. The final rule will reduce the add-on payment for new Part B drugs during the first three months of sales to 3% of the WAC in 2019.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Part B Payment for Opioid Treatment Programs (OTPs)

As directed by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, CMS is implementing an interim final rule with comment period that establishes a new Medicare benefit category for opioid use disorder treatment services delivered by OTPs, beginning in 2020. Under the rule, opioid use disorder treatment services will be required to include:

- Food and Drug Administration-approved opioid agonist and antagonist treatment medications;
- The dispensing and administration of such medications;
- Substance use disorder counseling;
- Individual and group therapy;
- Toxicology testing; and
- Other services determined appropriate, excluding meals and transportation.

CMS will accept comment on the interim final rule until December 31st. CMS is specifically requesting comment on services furnished by OTPs, payments for these services, and additional conditions for Medicare participation in OTPs.

Non-Physician Scope of Practice Provisions

In addition to physicians, the PFS establishes payments and requirements for a number of other providers, including nurse practitioners, physician assistants, physical therapists, and radiologist assistants. Provisions specifically affecting non-physician providers include:

- *Therapy Assistants* – BBA requires that outpatient therapy services delivered by a physical therapy assistant (PTA) or occupational therapy assistant (OTA) be decreased to 85% of the amount Medicare pays for ancillary professionals. As such, the final rule establishes new payment modifiers for when services are delivered in-whole or in-part by a PTA or an OTA in 2020. CMS will consider a service to have been furnished in-whole or in-part by a PTA or OTA when more than 10% of the service is furnished by the PTA or OTA. CMS will also retain the three existing therapy modifiers for physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services.
- *Radiologist Assistants* – The final rule will revise Medicare supervision requirements so diagnostic imaging tests conducted by a Radiologist Assistant may be conducted under the "direct supervision" of a physician, rather than the "personal supervision" of a physician. Personal supervision requires that the physician be in the same room, while direct supervision only requires that the physician be present on the same campus while the service is conducted.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Outpatient Therapy Reporting Requirements

The Middle Class Tax Relief and Jobs Creation Act of 2012 required that all providers of outpatient therapy services report on a beneficiary's functional limitation category and functional status in their claims for therapy services throughout an episode of care, including PT, OT, and SLP. The final rule will discontinue functional status reporting requirements for outpatient therapy in 2019.

Ambulance Services

Add-on payments for Medicare ambulance services were scheduled to end on December 31, 2017. As required by the BBA, the final rule will extend temporary add-on payments for ground ambulance services through 2022. The add-on payments will vary as follows:

- Urban areas will receive an add-on payment increase of 2%;
- Rural areas will receive an add-on payment increase of 3%; and
- Super-rural areas will receive an add-on payment increase of 22.6%.

The final rule will also increase the payment reduction from 10% to 23% for non-emergency basic life support transports for beneficiaries with ESRD for renal dialysis services, starting October 1, 2018.

QPP PROVISIONS

The PFS final rule also contains updates for the QPP in 2019. Under QPP, the PFS amounts paid to eligible providers will be adjusted according to the provider's participation one of the following tracks:

- The Merit-based Incentive Payment System (MIPS);
- Advanced Alternative Payment Model (APM);
- MIPS APM; or
- All-Payer Combination Option.

The final rule aims to generally ease reporting requirements, modify MIPS opt-in policy, expand the provider types eligible for MIPS, revise MIPS performance category weights and reporting requirements, and implement the All-Payer Combination Option and Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration.

MIPS

Under MIPS, providers have their payments adjusted according to their composite score in four performance categories. As required by statute, the maximum MIPS penalty is 7% of Medicare FFS revenue for performance year 2019, and the maximum MIPS bonus is 7%, subject to budget neutrality. The budget neutrality requirement reduces the total bonus so that it does not exceed the total penalties collected.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

MIPS Eligible Providers

The following providers are currently required to participate in MIPS if they meet certain Medicare revenue and beneficiary threshold requirements: physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. For 2019, the final rule will add four new types of clinicians to the list of eligible MIPS participants: clinical social workers, clinical psychologists, physical therapists, and occupational therapists.

Currently, providers or groups with less than $90,000 in Medicare-allowable charges or fewer than 200 Medicare beneficiaries are excluded from participating in MIPS. For 2019, a third exclusion category will be included: clinicians or groups that provide fewer than 200 covered services under the Medicare PFS. However, eligible providers will be able to opt-in to MIPS if they exceed at least one of the three thresholds.

To encourage MIPS participation among providers in small practices (15 or fewer clinicians) and rural or health professional shortage areas, a Virtual Groups Participation option was added in 2018. For the 2019 performance year, the Virtual Group eligibility determination period aligns with the first segment of data analysis under the MIPS eligibility determination period.

MIPS Performance Categories and Scoring

Under MIPS, providers have their payments adjusted according to their composite score in four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly "Advancing Care Information"). For 2019, the weight of the four measures will be:

- *Quality* – 45%, reduced from 50% in 2018;
- *Cost* – 15%, increased from 10% in 2018;
- *Improvement Activities* – 15%, unchanged from 2018; and
- *Promoting Interoperability* – 25%, unchanged from 2018. However, the rule will require the use of the 2015 Edition of Certified Electronic Health Record Technology (CEHRT). CMS will no longer allow the 2014 Edition. CMS also finalized a new scoring methodology that will require clinicians to report measures from each of four objectives: ePrescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.

In addition to these performance categories, CMS has added bonuses to the final score for providers that meet certain criteria:

- *Complex Patients* – CMS will maintain the five point bonus for providers treating complex patients, based on average Hierarchical Conditions Category risk scores and the proportion of full-benefit or partial-benefit dual eligible beneficiaries.
- *Small Practices* – The final rule will discontinue the five point bonus to the final overall score for eligible small practices in 2019. However, CMS will apply six point bonus for eligible small practices within the Quality performance category.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

MIPS eligible clinicians receive payment adjustments by comparing their final score to the performance threshold. Final scores at or above the performance threshold receive a neutral or positive payment adjustment equal to a maximum of 7% of Medicare FFS revenue for performance year 2019, while final scores below the performance threshold receive a negative payment adjustment of up to 7% of Medicare FFS revenue. For 2019, the performance threshold will be 30 points, up from 15 points in 2018. There will also be an additional performance threshold of 75 points, up from 70 points in 2018, for exceptional performance. The final rule provides flexibility in establishing the performance threshold for the next three years (Program Years Three through Five).

MIPS Facility-Based Physicians

Beginning in 2019, the final rule will expand eligibility for facility-based clinicians to have their Quality and Cost performance categories automatically scored according to their facility's performance. As such, eligible facility-based clinicians will not have to submit data at the individual-level. To be eligible for facility-based reporting at the individual-level, the clinician must:

- Deliver at least 75% of their covered professional services in an inpatient hospital, on-campus outpatient hospital, or emergency room;
- Have at least a single service billed at an inpatient hospital or emergency room; and
- Be attributed to a facility with a hospital Value-Based Purchasing Program score.

In order for the facility to be scored as a group, at least 75% of clinicians within a facility must be eligible for the facility-based measurement.

Advanced APMs

Under QPP, providers that participate in an Advanced APM and meet specified Medicare review and beneficiary thresholds are excluded from MIPS requirements and qualify to receive a 5% incentive payment (on top of payment for covered services). QPP Year Three (2019) will be the first year that eligible providers, referred to as Qualifying APM Participants (QPs), will receive incentive payments, based on 2017 performance.

For the 2019 performance year, CMS maintains that the following models will be eligible to qualify as Advanced APMs:

- Bundled Payment for Care Improvement Advanced;
- Comprehensive ESRD Care – Two-Sided Risk;
- Comprehensive Primary Care Plus;
- MSSP – Tracks 1+, 2, and 3;
- Next Generation ACO Model;
- Oncology Care Model – Two-Sided Risk;
- Comprehensive Care for Joint Replacement Payment Model – Track1-CEHRT; and
- Vermont All-Payer ACO Model.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

For an APM to qualify as an Advanced APM, it must also meet three criteria:

1. Require participants to use CEHRT. In 2018, at least 50% of eligible clinicians were required to use CEHRT. The final rule will increase this threshold to 75%.
2. Provide payments based on quality measures that are similar to those in MIPS. For 2019, CMS will consider MIPS-comparable measures to be those on the MIPS final list or endorsed by a consensus-based entity. In 2020, CMS will also consider measures determined by the Agency to be evidence-based, reliable, and valid.
3. Require that participants follow one of the following risk standards:
    - *Generally Applicable Standard* – The rule will maintain that the total potential risk for the APM must be at least 8% of the average Part A and B revenue of participating entities for performance years 2019 and 2020; or 3% of the expected expenditures of the Advanced APM for all performance years. The rule will extend the 8% revenue-based standard through 2024.
    - *Medical Home Model Standard* – For a Medical Home Model to be an Advanced APM, CMS maintains that the model must take on the potential risk of at least 4% of the average Part A and B revenue.

Advanced APM QPs

In order to be designated as a QP and receive a 5% Advanced APM incentive payment, providers must participate in an Advanced APM and meet certain Medicare and beneficiary volume threshold requirements. Providers who participate in an Advanced APM, but do not meet threshold requirements are subject to MIPS reporting and payment requirements. For 2019, CMS increased the payment and patient thresholds to define QPs as providers who:

- Receive at least 50% of Part B payments through an Advanced APM, up from 25% in 2018; or
- Deliver Part B services to at least 35% of their Medicare beneficiaries through an Advanced APM, up from 20% in 2018.

Providers that participate in an Advanced APM, but do not qualify as a QP at the individual-level may meet the slightly lower threshold requirements to become a Partial QP. Partial QPs may elect to participate in MIPS and receive MIPS payment adjustments, instead of the APM incentive payment. For 2019, CMS increased the Medicare payment and patient thresholds to define Partial QPs as providers who:

- Receive at least 40%, but less than 50%, of their payments for Part B services through an Advanced APM; or
- Deliver Part B services to at least 20%, but less than 35%, of their Medicare beneficiaries through an Advanced APM.

spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

MIPS APMs

CMS will continue the practice of allowing Advanced APMs to exclude certain participating providers from its scoring by leaving that provider off its Participation List. If a provider is not included in at least one Advanced APM Participation list per year, the provider will have to adhere to MIPS reporting requirements and have their payments adjusted to their composite score in the four MIPS performance categories, which are weighted slightly differently than regular (non-APM) MIPS performance categories.

The final rule clarifies the requirement for MIPS APMs to assess performance on quality measures and cost/utilization, but does not make significant changes to MIPS APM requirements.

All-Payer Combination Option

Providers may also become a QP based on their participation in a Medicare FFS Advanced APM and an Other Payer Advanced APM, collectively known as an All-Payer Advanced APM. Other Payer Advanced APMs must meet CEHRT, quality measure reporting, and risk standards that are comparable to Advanced APM standards. To be a QP or a Partial QP in the All-Payer Combination Option, providers will still have to meet specific Medicare FFS Advanced APM payment and patient thresholds, in addition to their participation in an Other Payer Advanced APM. For 2019, the thresholds will be:

Designation	Payment Amount		Patient Volume	
	Medicare FFS Minimum	Total	Medicare FFS Minimum	Total
QP	25%	50%	20%	35%
Partial QP	20%	40%	10%	25%

Participation in an Other Payer Advanced APM may be requested through a Payer-Initiated Process or an Eligible Clinician-Initiated Process:

- *Payer-Initiated Process* – CMS will continue the practice of allowing eligible payers to request an Other Payer Advanced APM determination. Eligible payment arrangements include those that are aligned with: Medicaid; CMS-Multi Payer Models; and Medicare Health Plans, including MA.
- *Eligible Clinician-Initiated Process* – Clinicians participating in other payer arrangements may request that CMS determine whether those payment arrangements are Other Payer Advanced APMs. The final rule will also allow determinations to be requested at the Tax Identification Number (TIN)-level, when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM entity.

60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

In 2018, CMS limited Other Payer Advanced APM determinations to one year and would have required eligible clinicians and payers to re-apply on an annual basis. The 2019 final rule will allow Other Payer Advanced APM applicants to request a multi-year arrangement, up to five years, as a part of their initial Other Payer Advanced APM submission.

MAQI Demonstration

CMS finalized its proposal to implement the MAQI Demonstration, which will allow MIPS-eligible clinicians who participate sufficiently in Advanced APM-like contracts with MA plans to be exempt from MIPS reporting requirements. To be eligible for the MAQI Demonstration, providers have to meet thresholds of combined participation in Qualifying Payment Arrangements with MA plans and Medicare FFS payment arrangements with Advanced APMs. Unlike the All-Payer Combination Option, providers will not have to meet specific thresholds of participation in a Medicare FFS Advanced APM. Thresholds of combined participation will be consistent with QP thresholds for Medicare FFS Advanced APMs. As such, MAQI Demonstration participations will be required to:

- Receive at least 50% payments through MA Qualifying Payment Arrangements and FFS Advanced APM; or
- At least 35% of their Medicare beneficiaries receive services through MA Qualifying Payment Arrangement and FFS Advanced APM.

CMS will consider Qualifying Payment Arrangements to be those that meet criteria consistent with Other Payer Advanced APM requirements.

The first application period for the MAQI demonstration closed on September 7th and CMS will notify applicants of their demonstration status in Fall 2018.