CMS Releases 2019 Quality Payment Program Proposed Rule

On November 1, 2018 the Centers for Medicare and Medicaid Services (CMS) released its final rule on the 2019 Quality Payment Program as part of the Physician Fee Schedule final rule.

In this rule CMS describes changes to policies for implementation of the third year for the Merit-Based Incentives Payment System (MIPS) and for Advanced Alternative Payment Models (APMs).

CMS is moving forward with weighting the cost category at 15% for 2019. As a result, the quality category will now be weighted at 45% while promoting interoperability (formerly called advancing care information) and improvement activities will remain at 25% and 15% respectively. Specific to the quality performance category, CMS has elected to maintain the data completeness requirement for quality measures at 60% for 2019. Bonus points will continue to be available for clinicians who submit additional high priority or outcome measures beyond the one required and for clincians who submit quality measures using end-to-end electronic reporting.

CMS finalized the title change of the "Advancing Care Information" MIPS performance category to "Promoting Interoperability," and finalized proposals for the minimum 90-day reporting period and realignment of the various special status determination periods. Additionally, CMS finalized the requirement of 2015 Edition certified EHR technology for those actively participating in the Promoting Interoperability performance category beginning in the 2019 performance period.

CMS is moving forward with applying the small practice bonus to the quality category instead of the final score, but modified its proposal to provide 6 rather than 3 bonus points for small practices submitting data to MIPS on at least one quality measure. CMS states that this bonus will incentivize participation without lowering the final score of small practices.

CMS has also elected to finalize the MIPS low-volume determination at $90,000 of Medicare Part B charges or 200 Part B-enrolled beneficiaries or 200 or fewer covered professional services to Part B-enrolled individuals. Therefore, any clinician who exceeds all three criteria will be required to participate in MIPS, while any clinician who falls below the threshold for any of the three criteria will be excluded from MIPS participation. In addition to this change to the low-volume determination, CMS has also finalized the ability for clinicians who fall below one or two, but not all, of the low-volume thresholds to "opt in" to the MIPS program. Clinicians who choose to opt in will then be included in the MIPS program and subject to MIPS payment adjustments for the full calendar year.

For 2019, CMS has also finalized criteria for clinicians to be identified as "facility-based" and therefore be eligible for facility-based measurement using the measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians. 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 measurement as individuals. There are no submission requirements for individual clinicians in facility-based measurement but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a group under facility-based measurement.

CMS codified its recognition of the importance of appropriate use criteria (AUC) for diagnostic imaging by maintaining high-weighted improvement activity (IA) credit for those referring physicians who are early adopters by participating in clinical decision support for 2019.

Additionally, CMS has maintained the seven medium-weighted improvement activities that participation in R-SCAN can fulfill for radiologists. Under MIPS, non-patient-facing physicians are required to earn two medium-weighted or one high-weighted IA, and patient-facing clinicians are required to earn four medium-weighted or two high-weighted IAs. CMS has included 93 IAs for 2019, many of which can be used by radiologists to meet the performance requirements in this category. CMS has added 6 new improvement activities, modified 5 existing improvement activities and removed one in this rule.

CMS finalized increasing the MIPS performance threshold for neutral adjustments from 15 points in 2018 to 30 points for 2019. Additionally, the exceptional performance bonus threshold has been raised from 70 to 75 points for 2019. By statute, the minimum and maximum MIPS payment adjustments increase from +/- 5% to +/- 7%; however the exact application of these adjustments will depend on a scaling factor to preserve budget neutrality.

Currently, there are several collection types for submitting MIPS data including Qualified Clinical Data Registry, Qualified Registry, EHR, Claims, and CMS Web Interface (for groups of 25 or more eligible clinicians). . Beginning in 2019, CMS will only allow individuals in small practices and small practice groups to use claims to report in the quality category. MIPS eligible clinicians and groups will be allowed to submit data collected via multiple collection types within a performance category beginning with the 2019 performance period

CMS has finalized the removal of two quality measures relevant to radiology: #359 Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging and #363 Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive. Measure #359 was finalized for removal because it is duplicative of measure #361: Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry. Measure #363 was finalized for removal because the quality action does not completely attribute to the radiologist.

CMS has finalized the inclusion of eight recently field-tested episode based cost measures for Knee Arthroplasty, Elective Outpatient Percutaneous Coronary Intervention (PCI), Revascularization for Lower Extremity Chronic Critical Limb Ischemia, Routine Cataract Removal with Intraocular Lens (IOL) Implantation, Screening/Surveillance Colonoscopy, Intracranial Hemorrhage or Cerebral Infarction, Simple Pneumonia with Hospitalization and ST-Elevation Myocardial Infarction (STEMI) with PCI. Participation in these episode based cost measures is voluntary and CMS has announced that the number of reportable episode based cost measures will increase with subsequent rulemaking cycles. For the acute inpatient medical condition episode-based measures, an episode is attributed to each MIPS eligible clinician who bills inpatient E&M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization. For the procedural episode-based measures, an episode is attributed to each MIPS eligible clinician who renders a trigger service as identified by HCPCS/CPT procedure codes. For the procedural episode-based measures, the case minimum is 10. For the acute inpatient medical condition episode-based measures specified, the case minimum is 20.The Medicare Spending Per Beneficiary (MSBP) and Total Per capital Cost (TPCC) measures are unchanged for 2019, but the attribution methodology for both is currently undergoing revision.

CMS will allow eligible clinicians to become Qualifying APM Participants (QP) utilizing the All-Payer Combination and Other Payer Options given that they are also participating in Advanced APMs with Medicare. Therefore the QPP allows for two options regarding how a physician

becomes eligible to become a Qualifying APM Participant, the Medicare option, which only takes into account participation in Advanced APMs with Medicare, and the combination of being a QP with Medicare and Other Payers who meet the CMS criterion. CMS also finalized that they will offer the alternative for QP determinations to be requested at the tax ID number (TIN) level in addition to the APM Entity and individual eligible clinician levels. The requirements for these APMs include the use of CEHRT by 75% of physicians in the APM, base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category including the use of one outcome measure, and a requirement that participants bear financial risk, which CMS is proposing to continue to define as 8% of revenues or 3% of expenditures.

ACR's MACRA Committee and staff are reading and digesting the final rule and will prepare a more detailed summary for publication in the near future. In the meantime, click here to read CMS' extensive fact sheet on the major changes in this rule for the third year of Medicare's Quality Payment Program for physicians who are required to participate in either APMs or MIPS.