November 2, 2018

CMS Releases 2019 MPFS/QPP Final Rule -- Impact on LTC for Year 3 of MIPS

Yesterday, the Centers for Medicare & Medicaid Services (CMS) released the 2019 Final Rule updating the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP), which encompasses the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). The rule makes changes to Year 3 of the Quality Payment Program (2019) and incorporates changes to the Medicare Shared Savings Program (MSSP ACO's), Telehealth/Remote Patient Monitoring, and Evaluation and Management Provisions.

GPM is in the process of analyzing the final rule for impact to LTC providers and to our software product. We strive to actively support and improve your workflow, while ensuring that we continue to capture the required information to maintain compliance and quality reporting requirements.

COMING SOON:

- *2019 MIPS PLANNING and SCORE CARDS: In the coming weeks, we will share options for how LTC providers in Small or Large Groups can achieve a bonus eligible score.*
- *WEBINAR: Also, stay tuned for an upcoming webinar with highlights, additional information, and what to expect for Year 3 of MIPS.*

Overview of Finalized Changes for the 2019 MIPS Program

- MIPS Component Weights (p.1001):
  - Quality – 45% (down from 50%)
  - Cost – 15% (up from 10%)
  - PI – 25%
  - IA – 15%
- MIPS Performance Periods (p. 967):
  - Quality – Full Year
  - Cost – Full Year
  - PI – 90 days
  - IA – 90 days
- Thresholds (p.927):
  - *NEW* Minimum threshold increased from 15 to 30 points.
  - *NEW* Exceptional performance increased from 70 to 75 points.
- Low Volume Threshold (p. 922)
  - Have ≤ $90K in Part B allowed charges for covered professional services;
  - Provide care to ≤ 200 Part B-enrolled beneficiaries; OR
  - *NEW* Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS) Maintaining the low-volume threshold for MIPS exemption at $90,000 or less in part B allowed charges or 200 or fewer Medicare beneficiaries.

- *NEW* Provider Types Added (p.887):
  - Physical therapist
  - Occupational therapist
  - Qualified speech-language pathologist
  - Qualified audiologist
  - Clinical psychologist
  - Registered dietitian or nutrition professionals
- Quality (p.1001)
  - *NEW* Skilled Nursing Facility Specialty Measure Set Finalized (pp. 2301-2302)
    - Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls will remain individual measures: Q154: Falls: Risk Assessment and Q155: Falls: Plan of Care within the set. *Composite measure proposal not finalized.*
- Promoting Interoperability (p. 1115)
  - *NEW* 2015 ONC Certified EHR Required
  - *NEW* Eliminating the base, performance and bonus score structure of the Promoting Interoperability category and replacing it with performance-based scoring on individual measures. (p.1136)
    - 4 Objectives based on the 2015 Edition CEHRT:
      1. e-Prescribing,
      2. Health Information Exchange,
      3. Provider to Patient Exchange,
      4. Public Health and Clinical Data Exchange
    - Each objective has varying number of measures
    - Must report 6 measures or claim exclusion
    - Two new *bonus* measures added to e-Prescribing objective
      1. Query of Prescription Drug Monitoring Program (PDMP)
      2. Verify Opioid Treatment Agreement
- Bonus Points:
  - End to End Reporting Bonus
    - 1 point for each measure submitted using end-to-end electronic reporting.
    - Capped at 10% of the denominator of total Quality performance category points.
  - Small Practice Bonus
    - *NEW* 6 bonus points are added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.
  - Complex Patient Bonus
    - 5-point bonus added to the MIPS Final Score for clinicians who treat medically complex patients.
  - PI Bonus for IA
    - *NEW* Discontinued for Year 3 Complex Patient Bonus:

- Data Submission (p. 1012, 1284)
    - 6 measure minimum, with at least one outcome measure, or one high-priority measure if no outcome measures are available
    - 60% Data completeness threshold - CMS to keep the 3-point floor for benchmarked measures; Small practices (15 or fewer clinicians) get 3 points for Class 3 measures; 20 cases minimum per measure
    - Allow individuals and groups to submit MIPS data using multiple submission types per category.

Brief Overview of Finalized Provisions from the 2019 MPFS NPRM

Evaluation and Management (p. 537)

CY 2019 and CY 2020

- CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines
- For both new and established patients, to no longer require providers re-enter information in the medical record regarding patients' chief complaint and history if that information was already entered by ancillary staff or the beneficiary

Starting in CY 2021

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.
- Implementation of a blended payment rate for E/M visits levels 2-4;
- Payment to adjust the base E/M visit rate(s) upward to account for visit complexity associated with non-procedural specialty care and primary care;
- Payment to adjust the base visit rate(s) upward to account for the additional resource costs when practitioners need to spend significantly more time with particular patients; and
- Flexible documentation requirements related to Medical Decision Making, Time or Current E/M visit documentation framework.

MSSP ACO (p. 837)

- CMS has finalized its proposal reducing the total MSSP quality measure set from 31 measures down to 23 measures on which ACOs' quality performance will be assessed for performance years during 2019 and subsequent performance years
- Finalizing proposal from the 2018 MSSP Proposed rule to remove *ACO-11-Percent of Primary Care Physicians Who Successfully Meet Meaningful Use Requirements.*
- Finalizing requirement to attest as part of the annual certification that a specified percentage of the ACO's eligible clinicians use CEHRT applicable for the performance year beginning on January 1, 2019, and subsequent performance years.

We will address additional CMS' finalized changes to the MPFS, MSSP ACO, and Hospital Final Rulemaking in future communication.

Resources

Below is a link to the CMS fact sheet and link to the final rule (unpublished version):

CMS 2019 Final Rule Fact Sheet
2019 Final Rule (unpublished version)

We will continue to keep you informed. If you have any questions, please contact the GPM Regulatory Team: MIPS@gEHRiMed.com