American Association of Neurological Surgeons
Congress of Neurological Surgeons

Preliminary Summary of the 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule

On July 12, 2018, the Centers for Medicare and Medicaid Services (CMS) released the Revisions to Payment Policies under Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements proposed rule with comment period. This is the first year that CMS is combining the Medicare PFS and the Quality Payment Program proposed rules. CMS is requesting comments on the proposed rule by September 10, 2018, and a final rule is expected to be released in November. The proposal contains some significant changes to Medicare's physician payment and quality programs, which consists of two participation pathways — the Merit-based Incentive Payment System (MIPS), which measures physicians based on four performance categories, and advanced alternative payment models (APMs) in which clinicians may earn incentive payments based on sufficient participation in these models. CMS has published several fact sheets on the rule including a fact sheet on the quality payment proposals for 2019. AANS/CNS expert volunteers on the Neurosurgery Quality Council and staff are continuing to review the rule and will draft responses to these proposals in the coming weeks. Below is a summary of some of the proposals included in the ***quality provisions*** of the draft regulation. The payment issues summary is be separately available.

General Issues

- **Estimated Impact of QPP**. CMS forecasts, based on legacy programs that predated MIPS, that 96% of clinicians in practices of all sizes will receive a positive or neutral payment adjustment in 2021 based on 2019 MIPS reporting. Approximately 92.5% of MIPS participants in practices of 15 or fewer will get a neutral or positive payment adjustment in 2021; 46.4% will get an "exceptional" payment adjustment. Finally, between 160,000 and 215,000 clinicians are estimated to be Qualified APM Participants in the third year of the program.

- **MIPS Expanded to New Clinician Types**. CMS uses statutory authority to expand MIPS eligible clinicians to new clinician types including physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

- **Low-Volume Threshold**. CMS retains the higher low-volume threshold, which excludes certain providers from MIPS, and is now proposing to add a third criterion for physicians to qualify for the low-volume threshold — providing fewer than 200 covered professional services to Part B patients. CMS is also proposing a new opt-in policy that allows practices to opt-in to participate in the MIPS program or create virtual groups if they meet or exceed one or two but not all of the low-volume threshold elements (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 proposes to set the overall performance threshold for determining bonuses or penalties at 30 points and the additional exceptional performance threshold at 80 points for performance year 2019. This compares to thresholds of 15 points and 70 points in 2018.

- **Medicare Part B Drugs**. Per the Bipartisan Budget Act of 2018, CMS proposes to remove Part B drugs from the low-volume threshold determinations and from physicians' payment adjustments.

- **Facility-Based Scoring Option.** 2019 is the first year physicians can choose to use a facility-based scoring option for the MIPS quality and cost performance categories. Specifically, in order to use 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). For groups, 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.

  Facility-based scoring will automatically be applied to MIPS eligible clinicians and groups who qualify and would benefit by having the facility-based score for their quality performance (vs. a traditional MIPS score), as long as they submit data under the Improvement Activity (IA) or Promoting Interoperability (PI) categories. CMS maintains the 30 percent floor, so any physician who scores below 30 percent via the facility-based reporting option would have their score reset to 30 percent in the quality performance category.

- **Multi-Category Credit.** In response to feedback provided by the AANS, CNS and AMA, CMS seeks comments on reducing reporting burden in the future by linking or otherwise bundling performance categories (e.g., creating sets of multi-category measures that would cut across difference performance categories and allowing clinician to report once for credit in all three categories) and/or creating public health priority measure sets.

- **Accounting for Social Risk Factors.** CMS proposes to maintain the complex patient bonus. CMS proposes to change the eligibility determination period for this bonus to October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the performance period occurs, similar to the proposed changes to the special status determination period.

Quality: Now 45 (rather than 50) percent of a physician's final score

- **Meaningful Measures Initiative.** CMS is continuing its Meaningful Measures initiative and notes it believes this will streamline reporting for physicians. Quality measure changes include adding ten new quality measures, removing 36 measures immediately, and removing 52 measures using a more gradual process for measure removal provided in the CY 2018 final rule. Neurosurgery-related measures proposed for removal include:

  - 423: Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy
  - 204: Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet

  As part of this effort, CMS proposes 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 proposes a high-priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination or opioid-related quality measure. We have concerns with the large number of measures being removed absent a reduction in quality reporting requirements and will further analyze how this will affect physicians in different specialties.

- **New Reporting Option.** CMS proposes to allow 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 proposes to limit the claims based reporting option to individuals who are in small practices. However, CMS also 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 three point floor for quality measures that do not meet the data completeness requirement. In addition, CMS proposes to move the small practice bonus points to a physician's quality category score. The small practice bonus points would be capped at 3 points for 2019.

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

- **Score Re-weighting.** CMS proposes to re-weight 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 still must report on six measures, including one outcome or high priority measure, and must meet the data completeness criteria of 60 percent of all denominator eligible patients, and must report a minimum of 20 cases. Physicians reporting via claims must report on 60 percent of Medicare Part B patients only and on a minimum of 20 cases.

  If a measure has a benchmark and a physician meets the data completeness criteria, they are eligible to receive three to ten points based on performance compared to the benchmark. If a physician fails to meet the data completeness criteria, they would only be eligible to receive three points. CMS proposes to reduce the point floor to one point in the 2020 performance period, except for small practices who would continue to receive three points if they do not meet the data completeness criteria.

- **Topped Out Measures.** CMS propose to remove extremely topped out measures more rapidly than previously finalized (i.e., in the next rulemaking cycle). For the 2020 payment year, six measures will receive a maximum of seven measure achievement points, provided that the applicable measure benchmarks are identified as topped out again in the benchmarks published for the 2018 performance period.

- **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.

- **Bonus Points.** For the 2019 performance year, CMS proposes to discontinue 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. The agency will, however, continue to assign bonus points for end-to-end reporting for the 2021 payment year as a way to incentivize reporting through electronic means.

- **Future Approaches to Scoring the Quality Performance Category.** CMS is seeking 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. For example, the agency seeks comment on implementing a system in the future where measures are classified as a particular value (gold, silver or bronze) and points are awarded based on the value of the measure.

Cost: Now 15 (rather than 10) percent of a physician's final score

- **Cost Category Weight.** Currently, 10 percent of physicians MIPS score is tied to costs. This was originally scheduled to rise to 30 percent in the 2019 performance year; however, legislation pushed by the AANS and CNS and adopted earlier this year authorized CMS to weight costs at any level from 10 percent to 30 percent through the next three years. CMS is proposing to increase the cost weight to 15 percent in 2019 and then increase it by an additional 5 percent in each of the next two performance years until it reaches the maximum 30 percent in the 2022 performance year.

- **Cost Measures.** The proposed rule would retain the two existing cost measures (Medicare Spending Per Beneficiary and Total Per Capita Cost of Care) with no changes and add eight new episode-based measures in 2019. One of these, the Intracranial Hemorrhage or Cerebral Infarction Episode Based Cost Measure, was developed with the input of organized neurosurgery. All of 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 percent reliability threshold for all of the cost measures in order to "measure as many clinicians as possible in the cost performance category." The agency is also considering increasing the length of the cost category measurement period to two years in the future so more physicians would meet minimum case thresholds to be counted in at least one cost measure.

  CMS would attribute these episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during the trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization. Note that 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. To be scored on this measure, a case minimum of 20 episodes is required.

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

- **2015 Certified Electronic Health Record Technology (CEHRT).** CMS proposes to require all physicians to use 2015 CEHRT in 2019.

- **Alignment.** CMS proposes to modify this category to better align with the recently proposed PI requirements for hospitals, including reducing the number of measures in this category.

- **Program Requirements.** CMS proposes to allow physicians to report fewer measures, and adopts a new performance-based scoring methodology, rather than the previous threshold approach. Proposals also include the elimination of the base, performance and bonus scoring. Instead, CMS would score physicians on a 100 point scale at the individual measure level. CMS also maintains the hardship exemption for this performance category.

- **New Measures.** CMS proposes to add two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement. It also consolidates two former measures into one new measure: Receive and Incorporate Health Information.

- **Hardship.** CMS would maintain hardship exemptions and exemptions for hospital-based clinician are maintained.

- **Reporting Period.** CMS proposes to allow physicians to report for any consecutive 90-day reporting period in 2019.

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

- **IA Reporting.** CMS proposes to maintain an attestation reporting option and a 90-day reporting period for the IA performance category. CMS also proposes to maintain reduced reporting requirements for small practices. CMS is proposing six new IAs, modifications to five existing IAs, and removal of one existing IA. Neurosurgery's proposed IA for serving on-call to the emergency department was, once again, not on the list.

- **Bonuses in PI Category.** The previous bonus that physicians could receive in the ACI / PI category for completing certain IA activities has been removed. As such, proposed IAs must meet one of CMS' other enumerated criteria to be considered for inclusion in the program (in previous years, an IA that could result in a PI bonus would be sufficient to be considered for inclusion by CMS).

- **New IA Criterion.** CMS is proposing to adopt 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.

Qualified Clinical Data Registries (QCDR)

CMS proposes revising the definition of QCDR to clarify that the approved entity must have clinical expertise in medicine and quality measure development, which is something the AANS/CNS has long pushed for. Beginning with 2019, QCDRs would be required to agree to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS. CMS would also move the self-nomination period up to July 1 to Sept. 1, 2018, rather than Sept. 1 to Nov. 1. In addition, CMS would require QCDRs to have at least 25 participants by January 1 of the year prior to the performance period.

Alternative Payment Models (APMs)

- **Advanced APMs.** CMS proposes to maintain the revenue-based financial risk requirement for Advanced APMs at 8% of revenues for an additional 4 years, from 2021 through 2024. Beginning in 2019 for Medicare APMs and 2020 for Other Payer APMs, CMS proposes to increase from 50% to 75% the percentage of an APM's participating physicians required to use CEHRT in order for APMs to qualify as Advanced APMs.

- **All-Payer Combination Option.** CMS proposes to allow participants in Other Payer APMs to describe their compliance with requirements that 50% of APM physicians use CEHRT, instead of mandating that APM payment contracts explicitly require use of CEHRT. CMS also proposes to add a third option to assess whether physicians have met the All-Payer threshold for Qualified APM Participants at the practice level (Taxpayer ID Number), in addition to the individual level and the APM Entity level. CMS also clarifies that APM participants can meet Medicare and Other Payer participation thresholds using patient counts for one threshold and payment counts the other threshold, whatever is most advantageous to the physician.

- **MAQI Demonstration**. The proposed rule waives requirements for MIPS reporting and MIPS payment adjustments for physicians participating in MA APMs, effective in 2018, whether or not the physician also participates in APMs for Medicare fee-for-service patients.

Physician Compare

CMS proposes not to publicly report first year quality and cost measures for the first two years a measure is in use to help clinicians and groups first gain feedback in program. CMS also proposes to only use an indicator for "successful" performance in the PI performance category starting with year two data. The agency also proposes to determine measure benchmarks based on historical data beginning with year three, and add star ratings for Qualified Clinical Data Registry (QCDRs) measures beginning with performance year two.

Medicare Shared Savings Program (MSSP)

To reduce burden, CMS proposes to eliminate ten measures and add one measure to the MSSP quality measure set beginning in performance year 2019. This would result in 24 measures for which ACOs would be held accountable. One of the measures proposed for removal is:

- **ACO-44: Use of Imaging Studies for Low Back Pain**, since this claims-based measure is restricted to individuals 18-50 years of age, which results in low denominator rates and is not a valuable reflection of the beneficiaries cared for by MSSP ACOs.

Requests for Information (RFIs)

- **RFI on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to CMS Patient Health and Safety Requirements for Hospitals and Other Medicare/Medicaid Participating Providers and Suppliers.** CMS issued a request for information on promoting interoperability and the electronic exchange of health care information.

- **RFI on Price Transparency: Improving Beneficiary Access to Providers and Supplier Charge Information.** The proposed rule includes a RFI on price transparency initiatives under consideration by CMS. In the RFI, CMS encourages all providers to undertake efforts to engage in "consumer-friendly communication of their charges and potential financial liability for the patient." The RFI is seeking input from responders regarding issues such as the definition of "standard charges," types of information beneficial to patients, potential requirements for providers and suppliers to provide out-of-pocket cost information to patients prior to services, and Medigap coverage and its impact of patient understand of out of pocket costs.

Please direct any Questions, Comments, and Clarifications to:

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