American Association of Neurological Surgeons
Congress of Neurological Surgeons

Summary of the 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule — Quality Provisions

On November 1, 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 final rule with comment period. This is the first year that CMS combined the Medicare PFS and the Quality Payment Program (QPP) proposed rules. The final rule 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 2019 QPP final Rule Executive Summary and a 2019 QPP Final Rule Overview Fact Sheet. Earlier in the year, AANS/CNS expert volunteers on the Neurosurgery Quality Council and staff provided substantive comments on the proposals in this rule. Below is a summary of some of the ***quality provisions*** finalized in this regulation. The payment issues summary is separately available.

General Issues

- **Estimated Impact of QPP**. CMS estimates that 97.8% of MIPS eligible clinicians will participate in MIPS in 2019, and of those, 91.2% are expected to receive positive or neutral payment adjustments. Approximately 80.1% of MIPS participants in practices of 15 or fewer will get a neutral or positive payment adjustment in 2021; 47.2% will get an "exceptional" payment adjustment. Finally, between 165,000 and 220,000 clinicians are estimated to be Qualified APM Participants in the third year of the program, qualifying for aggregate total APM incentive payments of approximately $600 million to $800 million for the 2021 payment year.

- **MIPS Expanded to New Clinician Types**. CMS used its statutory authority to expand MIPS eligible clinicians to new clinician types including physical therapists, occupational therapists, speech-language pathologist, audiologists, clinical psychologists, and dietitians. These clinicians are generally not required to comply with the Promoting Interoperability category, which will be automatically re-weighted to 0%.

- **Low-Volume Threshold**. CMS retained the higher low-volume threshold, which excludes certain providers from MIPS, and added a third criterion for physicians to qualify for the low-volume threshold — providing fewer than 200 covered professional services to Part B patients. CMS also finalized 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).

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- **Performance Threshold**. CMS finalized its proposal to set the overall performance threshold for determining bonuses or penalties at 30 points; however, it ultimately decided to set the additional exceptional performance threshold at 75 points (rather than 80 points) for performance year 2019. This compares to thresholds of 15 points and 70 points in 2018 and means that clinicians will have to report across more than one category of MIPS to avoid a penalty in year three.

- **Medicare Part B Drugs**. Per the Bipartisan Budget Act of 2018, CMS finalized its decision 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 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). 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. A facility-based clinician or group is attributed to the hospital at which they provide services to the most Medicare patients.

  Facility-based scoring will automatically be applied to MIPS eligible clinicians and groups who qualify and would benefit by having the facility-based performance score (vs. a traditional MIPS combined cost and quality score). For a group to qualify, it must also submit data under the Improvement Activity (IA) or Promoting Interoperability (PI) categories.

- **Multi-Category Credit.** In response to feedback provided by the AANS, the CNS and AMA, CMS will continue to consider ways to reduce 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 will maintain the complex patient bonus, which can add up to 5 points to a clinician's or group's final MIPS score. CMS modified 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, which aligns with other determination period changes finalized in this rule.

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

- **Meaningful Measures Initiative.** CMS is continuing its Meaningful Measures initiative in an effort to streamline reporting for physicians. Quality measure changes include adding eight new quality measures, including four patient-reported outcome measures, and removing 26 measures (versus the 36 proposed for removal). CMS also finalized its decision to revise the definition of a high-priority measure to include quality measures that relate to opioids.

  Neurosurgery-related measures finalized for ***removal*** in 2019 include:

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

  New neurosurgery-related measures being ***added*** in 2019 include:

  - 469: Average Change in Functional Status Following Lumbar Spine Fusion Surgery (MN Community Measurement)

- 471: Average Change in Functional Status Following Lumbar Discectomy Laminotomy Surgery (MN Community Measurement)
- 473: Average Change in Leg Pain Following Lumbar Spine Fusion Surgery (MN Community Measurement)

These new measures have been added to the Neurosurgical Specialty Set for 2019.

CMS also finalized changes to the following measure:

- 220: Functional Status Change for Patients with Low Back Impairments. CMS is expanding the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists.

- **New Reporting Option.** For the first time in 2019, CMS will allow for a combination of data collection types (e.g., claims, plus registry) for the quality performance category. If the same measure is submitted via multiple collection types, the one with the highest performance will be selected for scoring. CMS will also limit the claims-based reporting option for the first time in 2019, to individuals who are in small practices. However, CMS also expanded the claims-based reporting option to allow small *group practices* (15 or fewer eligible clinicians) to report via claims.

- **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.

- **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 and case minimum, 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 in 2019, they would only be eligible to receive one point (3 points for physicians in small practices). CMS also finalized its decision to reduce this point floor to zero points for 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.** Last year, CMS finalized a four-year lifecycle for identification and removal of topped out measures, as well as a scoring cap of 7 points for measures that have been topped out for two consecutive years. The definition and lifecycle for topped out measures remains the same for Year 3, although CMS finalized an additional policy that allows it to remove extremely topped out measures, defined as average mean performance within the 98th to 100th percentile range, in the next rule-making cycle. QCDR measures are excluded from the topped-out measure lifecycle and special scoring policies. If the QCDR measure is identified as topped-out during the self-nomination process, it will not be approved for the applicable performance period.

- **Small Practices.** For physicians in small practices, CMS maintains the three point floor for quality measures that do not meet the data completeness requirement (versus one point for other physicians). Also for 2019, although CMS will maintain the small practice bonus, the points will be added to a physician's quality category score rather than their MIPS final score. This bonus also would be capped at 3 points in 2019, versus 5 points in 2018.

- **Bonus Points.** For the 2019 performance year, CMS will continue to provide bonus points to incentivize the reporting of additional high priority measures and reporting through electronic means (i.e., end-to-end reporting).

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 the 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 finalized its decision to increase the cost weight to 15 percent in 2019.

- **Cost Measures.** For 2019, CMS will retain the two existing cost measures (Medicare Spending Per Beneficiary, or MSPB, and Total Per Capita Cost of Care, or TPCC) and add eight new episode-based measures in 2019. This will represent the first year that CMS actually holds physicians accountable for episode-focused costs; previously, episode-based cost measure data was only provided through confidential feedback reports.

  One of these episode-based measures, the Intracranial Hemorrhage or Cerebral Infarction Episode Based Cost Measure, was developed with the input of organized neurosurgery, but was intentionally crafted to exclude the costs of surgery and instead focus on medical management of stroke. All of the cost measures finalized for 2019 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."

  CMS also finalized some changes to the attribution methodology used for the episode-based cost measures, which could result in more clinicians being attributed a sufficient number of beneficiaries to be scored on these measures. For example, for acute inpatient medical condition episodes, CMS will attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E/M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E/M claim lines in that hospitalization. Currently for this type of measure, CMS attributes episodes to physicians who *individually* exceed the 30% E/M threshold. To be scored on an acute inpatient medical condition episode measure, a case minimum of 20 episodes is required. Procedural episodes require a case minimum of 10, while the TPCC measure requires at least 20 attributed cases and the MSPB requires 35.

Promoting Interoperability (PI): 25 percent of a physician's score

- **2015 Certified Electronic Health Record Technology (CEHRT).** CMS finalized its requirement that all physicians use 2015 Edition CEHRT in 2019 in order to comply with this performance category.

- **Alignment.** CMS adopted changes that will allow this category to better align with the recently finalized PI requirements for hospitals, including reducing the number of measures in this category.

- **Program Requirements.** CMS adopted a single, smaller set of objectives and measures. CMS also eliminated the confusing approach of base, performance and bonus scoring. Starting in 2019, all PI measures will be scored based on measure performance. To receive a score in this category, a clinician or group must report at least one patient in the numerator of each measure, and satisfy a yes/no statement for one of the measures, or claim an exclusion for each applicable measure.

- **New Measures.** CMS added two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement. In recognition of ongoing technological barriers to complying with these measures, CMS decided that these measures would be optional and eligible for bonus points in 2019.

- **Hardship.** CMS maintains hardship exemptions and automatic exemptions for hospital-based clinician for 2019.

- **Reporting Period.** CMS maintains a minimum 90-day reporting period in 2019.

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

- **IA Reporting.** CMS will maintain an attestation reporting option and a 90-day reporting period for the IA performance category. CMS also will maintain reduced reporting requirements for small practices. CMS added six new IAs, including **"**Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support" and "Patient Medication Risk Assessment," both of which focus on opioid use management. Neurosurgery's proposed IA for serving on-call to the emergency department was, once again, not accepted.

- **Bonuses in PI Category.** The previous bonus that physicians could receive in the PI category for completing certain IA activities using CEHRT has been removed.

- **New IA Criterion.** CMS also finalized the 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 finalized multiple proposed policies related to QCDRs that would take effect in 2020, including:

- An updated definition to ensure QCDRs have clinical expertise in medicine and quality measure development
- A requirement that the QCDR must have at least 25 participants by January 1 of the year ***prior to*** the performance period
- A longer, but earlier QCDR self-nomination period (July 1-Sept. 1, rather than the current Sept. 1-Nov 1).
- Applying select criteria used under the general MIPS Call for Measures Process when considering QCDRs. CMS is also considering requiring, through future rulemaking, reliability and feasibility testing as an added criteria in order for a QCDR measure to be considered for MIPS.
- Due to a strong push from the AANS and CNS and members of the Physician Clinical Registry Coalition (PCRC), CMS did NOT finalize, at this time, its proposal to require QCDR measure owners to agree to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure for purposes of MIPS. Rather, it is retaining its existing policy that QCDR vendors may seek permission from another QCDR to use an existing measure that is owned by the other QCDR.

Alternative Payment Models (APMs)

- **Advanced APMs.** CMS will 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 will 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.** Eligible clinicians who participate in an Advanced APM can become Qualifying APM Participants (QPs) for a year by meeting certain threshold levels of participation in these types of APMs, measured in terms of either their Medicare payments or patients. If an eligible clinician does not meet the threshold levels of participation to become a QP based only on participation in Advanced APMs with Medicare, starting in the 2019 performance year, they can also count their participation in Other Payer Advanced APMs to potentially become a QP for the year (so long as minimum Medicare thresholds are met). Beginning in 2019, CMS will allow for QP determinations under the All-Payer Option to be requested at the TIN level, in addition to the APM Entity and individual eligible clinician levels, when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity.

- **Payer-Initiated Process**. CMS finalized a process to allow select payers — including Medicaid, Medicare Advantage plans, and participants in multipayer Innovation Center models — to submit payment arrangements for consideration as Other Payer Advanced APMs, starting in 2018 (for the 2019 All-Payer QP Performance Period).

- **MAQI Demonstration**. The final 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 finalized its decision to not 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 decided not to use an indicator of "high" performance and to instead only use an indicator for "successful" performance in the PI performance category starting with year two data. The agency also finalized the use of measure benchmarks based on historical MIPS data beginning with year three, and use of the ABC™ methodology to determine benchmarks and 5-star ratings for Qualified Clinical Data Registry (QCDRs) measures beginning with performance year two. Currently, the 5-star rating methodology only applies to traditional MIPS measures.

Medicare Shared Savings Program (MSSP)

To reduce burden, CMS is eliminating 9 measures and adding two measures to the MSSP quality measure set beginning in performance year 2019. This would result in 23 measures for which ACOs would be held accountable. One of the measures finalized for removal is:

- **ACO-44: Use of Imaging Studies for Low Back Pain**: According to CMS, 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.

Please direct any Questions, Comments, and Clarifications to:

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