APA SUMMARY OF THE 2019 FEE SCHEDULE AND QUALITY PAYMENT PROGRAM FINAL RULE?

As it does each year, CMS made revisions to the Medicare Physician Fee Schedule and Quality Payment Program rules for 2019. The following is a summary of the changes that psychiatrists will see 2019. This summary includes an overview of the CPT coding changes for 2019. To see the entirety of APA's comments to CMS on the ideas that were proposed, please follow this link [APA Comments on 2019 Medicare Fee Schedule and Quality Payment Program proposed rule .]

2019 Medicare Physician Fee Schedule Payment Update

Conversion Factor and Malpractice Value

For 2019, the fee schedule conversion factor (the dollar multiplier for relative value units that determines reimbursement) will be $36.04.

Evaluation and Management (E/M) Documentation Changes

CMS had crafted a proposal that made a meaningful attempt to address the complexities of the current evaluation and management documentation guidelines and pared it with a significant proposal to simplify the payment structure. The documentation changes will go into effect in 2019 but the payment structure changes have been delayed until at least 2021 (see below).

Although APA concurred with CMS's proposed changes to the current documentation requirements for E/M services, we expressed concerns that the proposed simplification of the fee structure could have unintended consequences that would negatively impact beneficiary access to care.
CMS finalized the following documentation changes, which can be implemented beginning in January 2019:

- Physicians are no longer required to document the medical necessity for treating patients in their homes rather than in the office;
- When there is already relevant information in the record for established patients, physicians can choose to focus their documentation on what has changed since the last visit or pertinent items that have not changed. You no longer have to re-record elements of history and exam when there is documentation that those items have been reviewed and updated;
- CMS will allow physicians to indicate they have reviewed and verified information on the chief complaint and history that is already recorded in the record by ancillary staff or the patient; and
- CMS has removed potentially duplicative requirements for notations that may have already been included in the record by residents or other members of the team for E/M visits provided by a teaching physician.

CMS posted an FAQ for its released FAQ regarding E/M history documentation; please follow this link to access it https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/E-M-Visit-FAQs-PFS.pdf

Evaluation and Management Payment and Coding Changes

For 2019, CMS has maintained separate fees for each of the five levels of E/M services used to describe care for new and established patients in the office/outpatient setting.

Changes Slated for Implementation Beginning in 2021

Beginning in 2021, CMS plans to implement a blended payment for both new and established office/outpatient E/M visits, paying the same amount for levels 2 through 4. Level 5 will be paid at a higher amount to account for work in providing care to the most complex patients. CMS has also created new add-on codes, including one that can be used by psychiatrists and others to account for visit complexity associated with an E/M service. A new "extended visit" code will also be put in place to account for additional resources required when a level 2, 3, or 4 service requires additional time. A chart on the CMS website provides the details of the planned 2021 E/M code structure.

In addition to the simplification of the payment amounts, CMS proposes to permit physicians the option of documenting office/outpatient E/M visits using medical decision making, time, or the existing 1995 or 1997 E/M documentation guidelines. Time would be an option whether or not the time was spent on counseling and/or coordination of care. Again, these changes are set to begin in 2021, and CMS remains open to feedback on these items.

Interprofessional Technology-based Services Codes

For 2019, CMS added another nine new CPT and HCPCS codes (G2012, 99446-99449, 99451, 99451) to the fee schedule, describing interprofessional technology-based services. This includes a HCPCS code (G2012) that describes a brief (5 – 10 minute) check-in by phone. Keep in mind that patient cost-sharing under Medicare will apply when billing these services, so you'll want to be sure to make patients are aware of this if you choose to use these codes.

Care Management Coding in RHCs and FQHCs

CMS expands the number of billable HCPCS/CPT codes for use by rural health clinics (RHCs) and federally qualified health centers (FQHCs). CMS expanded the range of care management services that are separately billable in this setting by including code 99491 (chronic care management, 30 minutes or more) in the group of services that are billed under HCPCS code G0511.

Communication Technology-Based Services and Remote Evaluations in FQHCs and RHCs

CMS finalized a HCPCS code for communication technology-based services and adds a policy to pay it separately from the FQHC and RHC per diems. Effective January 1, 2019, RHCs and FQHCs are paid for HCPCS code G0071 (virtual communication services), when certain criteria apply.

Bundled Episode for Management and Counseling Treatment for Substance Use Disorders

CMS expressed its interest in providing coverage for treatment of patients suffering from substance use disorders, including opioid addiction. Given that Medicare has no comprehensive SUD treatment benefit, including reimbursement for services delivered or drugs dispensed by an Opioid Treatment Program (OTP), APA urged CMS to take several steps toward the creation of a reimbursement bundle for medication-assisted treatment services for substance use disorders (SUDs). CMS chose not to finalize policy on this issue and will consider comments in consideration for future rulemaking.

Telehealth for SUD: Originating Site

As an outgrowth of the SUPPORT for Patients and Communities Act (i.e., the "opioid bill/package"), beginning on July 1, 2019, CMS will waive originating site and geographic restrictions for Medicare beneficiaries with a substance use disorder or with a substance use disorder and a co-occurring mental health diagnosis. This will allow patients to be seen in the home. Previously they would have had to present at a qualified "originating site,"(e.g., a hospital or doctor's office) to receive telehealth services and also would have been required to be in a rural area.

Promoting Interoperability

The “Advancing Care Information” performance category of MIPS has been renamed “Promoting Interoperability.”

APA supported, and CMS agreed to, the performance-based approach to determining eligible clinicians’ scores on the Promoting Interoperability performance category.
CMS finalized the performance-based approach, with some modifications. For example, failing to report on any of the performance-based measures will automatically shift the allotted points to another measure.

For example, the 40 possible points that can be earned under the two, new, consolidated measures under Health Information Exchange Objective (Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Incorporating Health Information) are generally distributed to 20 points per measure.

However, if an eligible clinician takes an exclusion for one measure under this objective, such as:

- Having 100 fewer transitions of care or 100 fewer encounters with patients never encountered before, or
- Being unable to implement the measure for a MIPS performance period for 2019

Then, the 20 points from one measure are re-allocated to another.
Also, the elimination of the base versus performance score was finalized. However, there are still “required” measures, and if the eligible clinician does not report on any of these, they automatically receive a score of zero in Promoting Interoperability.

The final rule eliminated burdensome, patient-driven measures that proved particularly challenging for psychiatrists (e.g., Patient-Specific Education, Secure Messaging, Patient-Generated Health Data, View, Download, or Transmit) and consolidated others (e.g., Request/Accept Summary of Care, Clinical Information Reconciliation).

The two renamed/re-envisioned measures (e.g., Supporting Electronic Referral Loops by Sending Health Information; Provide Patients Electronic Access to their Health Information) have been challenging to successfully report due to the unique nature of psychiatric workflows. Attaining the maximum combined 60 points under the proposed performance score methodology for the "Provider to Patient Exchange" and "Health Information Exchange" Promoting Interoperability measures might still prove challenging for many psychiatrists, particularly due to the limited capacity for some psychiatric patients to engage with their electronic record. However, CMS finalized the scoring for these two performance measures to a total 80 possible points, with certain exclusions/reallocation of said points under certain scenarios.

The final rule allows for one permissible prescription to satisfy minimum reporting requirements. The one prescription will simply be added to the numerator for this measure and the eligible clinician will receive the lowest possible score for performance, although APA recommended that the final rule follow previous rulemaking in allowing "one permissible…" activity to count toward full participation in the various measures under the Promoting Interoperability category (e.g., "at least one permissible prescription written by an eligible clinician…").

CMS will not require the Health Information Exchange Across the Care Continuum (Health Information Exchange Objective) measure for 2019. When or whether the agency will require it is unclear. Per CMS, "We are working to introduce additional flexibility to allow MIPS eligible clinicians a wider range of options in selecting measure that are most appropriate to their setting, patient population, and clinical practice improvement goals."

CMS received and will consider numerous comments on these issues as the agency develops future policy regarding the potential new measures.

Transition to Sole Use of 2015 CEHRT

In the 2019 reporting year, CMS will not allow a one-time, Promoting Interoperability exception to eligible clinicians who used 2014 or a combination of 2014/2015 CEHRT for the 2018 Quality Payment Program reporting year. CMS will require that only 2015 CEHRT may be used for all future reporting years. Those using 2014 or a combination of 2014/2015 technology need to make the transition beginning in the 2019 reporting year and can search for options in the ONC's Certified Health Product List (CHPL).

Query of Prescription Drug Monitoring Program (PDMP)

APA commented that PDMP integration is not currently in widespread use for CEHRT, and many eligible clinicians would potentially need to change workflows at the point of care before they can meet this measure without experiencing a significant burden.

Work flows are already burdensome when using PDMPs in practice. It takes a significant amount of time to query PDMPs due to additional steps of logging into systems, entering patient data for querying purposes, and using two-factor authentication. Requiring that physicians engage in these practices to meet measure thresholds would add to this burden. However, better integration of PDMPs into CEHRT would help to mitigate these issues.

In the final rule, CMS acknowledged the potential burdensome nature of this proposed, new measure. For 2019, the measure is worth a 5-point bonus. For 2020, CMS indicates that it will address how the measure will be scored/handled in future rulemaking.

Verify Opioid Treatment Agreement

APA urged caution against the widespread adoption of this measure into the Promoting Interoperability framework, citing circumstances that potentially could result in net negative outcomes. However, CMS finalized this measure. It is worth a 5-point bonus for 2019 reporting year and is also proposed as a 5-point bonus for the 2020 reporting year.

CALENDAR YEAR 2019 UPDATES TO THE QUALITY PAYMENT PROGRAM

MIPS Eligible Clinicians

CMS has expanded the definition of eligible clinicians to include clinical psychologists. CMS originally proposed to include social workers as well but decided not to do that at this time.

MIPS Participation Criteria

For 2019 CMS expanded the ways in which individual eligible clinician or groups (including APM Entity group) can qualify for the low-volume threshold. Those that meet one or more of the following will be exempted from MIPS:

- If allowed charges for covered professional services less than or equal to $90,000, or
- if covered professional services are provided to 200 or fewer Medicare Part B-enrolled individuals, or
- (New) if 200 or fewer covered professional services are provided to Medicare Part B-enrolled individuals.

CMS continues to allow a clinician to voluntarily opt in to MIPS reporting, if he/she exceeds one or two, (but not all three), of the low-volume threshold criteria. A clinician who is eligible to opt-in would be required to formally elect to opt into MIPS, or elect to be a voluntary reporter.

Psychiatrists who exceed the CMS Merit-based Incentive Payment System's (MIPS) low-volume threshold will notice changes when collecting and submitting quality measurement data as part of the Quality Performance Category. For the 2019 program year, the Quality Performance Category will make up 45 percent of the total MIPS composite score, rather than 50 percent as it did in 2018. CMS finalized the increase to the MIPS performance threshold to 30 points and the exceptional performance bonus to 75 points in program year 2019, although APA recommended that CMS delay the proposed increase to the exceptional performer points threshold until stakeholders receive and review feedback on the success rates of MIPS eligible clinicians. APA also recommended that CMS make available the rates at which eligible clinician-psychiatrists exceeded the exceptional performance points threshold during the 2017 MIPS performance year.

Terminology Updates and Impact on Measure Data Completeness

New terms have been adopted for how the measure data is collected and submitted. The purposes of these terminology updates are intended to streamline and reflect user experiences. More specifically, psychiatrist-eligible clinicians should expect to learn the difference between the terms listed below. CMS states that resource information describing these terms will be available on the QPP.gov website shortly after the start of the 2019 performance year.

- **Collection Type** describes a measure's designated method of capturing data. Examples include Medicare Part B claims (billing claims/measure coding), electronic clinical quality measures (eCQMs—implemented in an electronic health record (EHR) system), MIPS clinical quality measures (MIPS CQMs—clinical data registry specified measures), and CMS's Web Interface. Quality measures may be the subject of multiple collection types.
- **Submitter Type** is the entity that submits the measure data to CMS. This can be an eligible clinician (EC), a designated representative of a group practice, or a third-party (e.g., Qualified Clinical Data Registry(QCDR), such as APA's mental health registry PsychPRO or CMS's Web Interface).
- **Submission Type** describes the mechanism to transmit measure data to CMS. Because there are multiple data collection types, there are multiple submission types. The following is a list of submission types.
  - Direct submissions include EHRs or QCDRS.
  - Log-in and upload requires CMS authorization credentials to transmit data.
  - Log-in and attest may be used to confirm eligible clinicians' participation in MIPS' Improvement Activities Performance category.
  - Medicare Part B claims billing may capture measures specified for this collection and submission type (measure codes must be included at the time the bill is submitted to CMS).
  - CMS Web Interface is an option available for groups with providers billing under the same tax identification number (TIN) with no fewer than 16 clinicians.

Collection type	Data completeness
Medicare Part B claims measures (Reportable by Small Practices* Only)	60 percent of individual MIPS eligible clinician's, or group's Medicare Part B patients for the performance period.
QCDR measures, MIPS CQMs, and eCQMs (Reportable by all participating clinicians)	60 percent of individual MIPS eligible clinician's, or group's patients across all payers for the performance period.
CMS Web Interface measures (Reportable by practices with no fewer than 16 eligible clinicians)	Sampling requirements for the group's Medicare Part B patients: Populate data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries
CAHPS for MIPS survey measure (Reportable through a certified vendor by group practices of two or more eligible clinicians)	Sampling requirements for the group's Medicare Part B patients.

CMS defined the amount of data (according to data collection type) required for MIPS participating clinicians. The percentages demonstrating data completeness have remained the same as in performance year 2018, but because of the changes in terminology, they are described in the table below.

Data Submission Deadlines

Unlike the performance period of other MIPS performance categories, the Quality Performance Category lasts a full program year, or January 1 through December 31 of the current program year. Measure data must be transmitted to CMS no later than March 31 of the following year to be accepted for scoring. For instance, measure data collected during the 2019 performance year must be received by CMS no later than March 31, 2020. Otherwise, eligible clinicians will not earn Quality Performance Category Scores for their 2019 performance and this will negatively impact their 2021 payment.

Quality Measures Included in the 2019 Performance Year for the Quality Performance Category

As in prior MIPS program years, eligible clinicians' scores will be based on their submitted measure data, as well as the data completeness of the measures. Despite the measure collection type, to earn as many points as possible under the Quality Performance Category, participating psychiatrists must report six quality measures including one outcome measure. If an appropriate outcome measure is not available, a high-priority measure may be used instead.

For 2019, CMS updated the high-priority measure domains. In addition to the appropriate use, patient safety, efficiency, patient experience, and care coordination domains, "opioid-related" quality measures are added.

In the 2019 MIPS final rule, CMS announced that it will incrementally remove measures identified as low-value (including process-based) measures. However, it did not describe how the removal decision will be made. APA will closely monitor this determination and work with CMS to ensure measures pertinent to psychiatry will remain (at least until more meaningful tools replace them), or advocate for reduced measure reporting criteria.

Measures available in the 2019 performance year include 25 quality measures that psychiatrists should be able to report on, given their subject matter. However, those who do not fit the criteria for a small practice will not be able to report Medicare Part B claims measures data anymore. There is a selection of non-claims-based measures that are available and reportable through certified EHR systems and through APA's QCDR, PsychPRO.

The measures included in the 2019 MIPS final rule are organized into measure specialty sets, and it is likely most eligible clinicians will be able to find their six measures within their specific specialty set. However, eligible clinicians may select measures outside their measure set to satisfy the six-measure/one-outcome or high-priority measure criteria.

The 2017 final rule contained a sentence that has caused confusion for MIPS APM participants, and appears to discourage entities from reducing the costs of care and/or utilization. In 2019, CMS revises the language from "the APM bases payment incentives on performance (either at the APM entity or eligible clinic level) on cost/utilization and quality measures" to state "the APM bases payment incentives on performance (either at the APM entity or eligible clinic level) on quality measures and cost/utilization."

Cost Performance Category

In the proposed rule for performance year 2019, CMS reminds the public that in the previous final rule, the cost (resource use) performance category was scheduled to be re-weighted to 15 percent for MIPS payment year 2021, up from ten percent in payment year 2020. APA disagreed with the proposal, noting that there are no directly relevant episode-based measures for psychiatrists, and recommended that the cost category weight be maintained at 10 percent for at least another year, or until all MIPS eligible clinicians have episode-based measures available to them. APA urged the Secretary to exercise regulatory authority latitude to delay the increase in category weight. In the end, CMS did not accept this recommendation and the cost category weight will increase to 15% in performance year 2019.

To expand the cost category for performance year 2019, CMS adds eight new, procedure-focused, episode-based cost measures for performance year 2019. Of the eight measures, none are directly applicable to psychiatric services. This means that psychiatrists will continue to be assessed on only their performance in the Medicare Spending Per Beneficiary and Total Cost Per Beneficiary Cost measures, as they were in 2018 (when the cost category weight was zero percent).

Improvement Activities Performance Category

In 2019, QPP adds several Improvement Activities and one new criterion that should expand the reporting options for psychiatrists. CMS finalized adding "Include a Public Health Emergency as Determined by the Secretary" to the criteria for nominating new improvement activities to the inventory. Additionally, CMS will add new Improvement Activities, including:

1. **IA_BMH_10 Completion of Collaborative Care Management Training Program** (medium weight). CMS references the collaborative care management (CoCM) training developed by the American Psychiatric Association through the Transforming Clinical Practice Initiative
2. **IA_BE_24 Financial Navigation** (medium weight)
3. **IA_ CC_18 Relationship-Centered Communication** (medium weight)
4. **IA_PSPA_31 Patient Medication Risk Education** (high weight)
5. **IA_PSPA_32 Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain Via Clinical Decision Support** (high weight)

CMS will make modifications to these existing Improvement Activities:

1. **IA_CC_10 Care Transition Documentation Practice Improvement** (medium weight)
   The change adds examples of how the care plan could be documented:
2. **IA_PM_13 Chronic Care and Preventive Care Management for Empaneled Patients** (medium weight)
   The change adds examples of evidence based, condition-specific pathways that could be used for the care of chronic conditions

3. **IA_PSPA_2 Participation in Maintenance of Certification (MOC) Part IV** (medium weight)
   The change adds two examples of ways a that MIPS eligible clinician could participate in MOC Part IV
4. **IA_PSPA_8 Use of Patient Safety Tools** (medium weight)
   The change adds an example/category of an action that could meet the activity requirements
5. **IA_PSPA_17 Implementation of Analytic Capabilities to Manage Total Cost of Care for Practice Population** (medium weight) The change adds an example platform that uses available data to analyze opportunities to reduce cost through improved care.

Resources:

- **APA comment letter on the 2019 Medicare fee schedule and QPP proposed rule**
- **APA CPT coding and payment**
- **CMS 2019 final rule fact sheet**