On July 12, 2018, CMS published its annual update to the Medicare Physician Fee Schedule (PFS) for public inspection. The proposed rule includes numerous proposals that would also impact the Quality Payment Program Year 3, the Medicare Shared Savings Program, and the Medicaid Promoting Interoperability Program for Calendar Year 2019, as well as the Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration. Among the most notable changes in the rule are the proposals to revise documentation requirements and payment rates for Evaluation and Management (E/M) visits. Highlighted below include these and other proposed policy changes of importance for AOA members.

PHYSICIAN FEE SCHEDULE HIGHLIGHTS

Evaluation and Management Visits: The proposed rule includes sweeping documentation and payment policy changes for Evaluation and Management (E/M) services, mainly applicable to Level 2 through 5 Office/Outpatient visits. Specifically, CMS is proposing to allow clinicians the option to either document Medical Decision Making (MDM), the amount of time, or continue using the current 1995 or 1997 guidelines as a basis to determine the appropriate level of E/M visit. For established patients, clinicians would be required to focus their documentation of the History of Present Illness (HPI) and Examination (exam) on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list or required elements, such as review of a specified number of systems and family/social history.

For both new and established patients, clinicians would be able to review and verify the chief complaint and history information documented in the medical record by ancillary staff or the beneficiary, instead of having to re-enter the information. If adopted, the proposal would apply single payment rates for Level 2 through 5 Office/Outpatient visits for new and established patients (CPT codes 99202-99205 and 99212-99215), along with a minimum documentation standard consistent with the history, exam and/or MDM associated with a Level 2 visit (except when using time as the determining factor).

New Patient CPT Code Office/ Outpatient Visits	Current Payment Rate	Proposed Payment Rate	Established Patient CPT Code Office/Outpatient Visits	Current Payment Rate	Proposed Payment Rate
99201	$45	$44	99211	$22	$24
99202	$76	$135	99212	$45	$93
99203	$110		99213	$74	
99204	$167		99214	$109	
99205	$211		99215	$148	

CMS further proposes to implement a variety of approaches to better capture duplicate and additional resource costs for complex E/M visits, prolonged face-to-face visits, podiatry visits, and indirect practice expense. In doing so, CMS would create a new add-on HCPCS G-code (*GPC1X –Visit complexity inherent to evaluation and management associated with primary*

medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit)) to reflect the inherent complexity and additional resources associated with certain types of primary care services for established patients. A separate new add-on HCPCS G-code would also be created for certain specialties (*GCG0X - Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology,* cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)).

In the rule, CMS proposes to apply a 50 percent reduction to the least expensive procedure or visit furnished on the same day as a separately identifiable E/M visit appended with Modifier -25 when performed by the same physician within a global service period.

For E/M visits furnished in the home (CPT codes 99341-99350), CMS proposes to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home, rather than in the office.

CMS also seeks public comments on whether to eliminate the provision that prohibits payment for two E/M office visits billed by the same physician on the same day (or a physician of the same specialty in the same group practice).

The rule would also amend documentation requirements for teaching physician E/M visits to allow for the physician, resident or nurse to document the presence and extent of the physician's participation in the medical record. Current regulations require the teaching physician to personally document their participation in the medical record.

CMS proposes to implement the alternative documentation changes effective January 1, 2019, but seeks feedback on whether a delayed implementation date of January 1, 2020 would be more appropriate.

Conversion Factor: For 2019, CMS estimates the conversion factor (CF) to be 36.05, a slight increase from the current CF of 35.99. The estimated CF for 2019 reflects a statutory adjustment of 0.25 as required by the Bipartisan Budget Act of 2018, and a -0.12 percent RVU budget neutrality adjustment.

Substance Abuse Disorders: CMS also seeks comment on creation of a bundled episode of care for management and counseling treatment to help prevent opioid use disorder, specifically development of non-opioid alternatives for pain management.

Part B Drugs: Starting January 1, 2019, CMS proposes to reduce the add-on payment from six percent to three percent for Part B drugs based on wholesale acquisition cost (WAC). The proposed change would only apply in instances when average sales price (ASP) data is unavailable, and would correlate with President Trump's budget proposal for Fiscal Year 2019

and recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its June 2018 Report to Congress.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Starting January 1 2019, CMS proposes to create a new Virtual Communications G-code to allow RHCs and FQHCs to receive additional payment for the costs of communication technology-based services and remote evaluations when there is no associated billable visit.

Appropriate Use Criteria: CMS proposes to modify existing requirements and criteria for the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging services to allow ordering professionals to self-attest to significant hardship exceptions if they experience 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances. In addition, CMS proposes to include independent diagnostic testing facilities (IDTF) in the definition of applicable settings, use of a HCPCS G-code and modifiers to report use of AUC on claim forms, and to allow licensed clinical staff working incident to the ordering physician to perform consultation of AUC through a qualified CDSM. No changes are proposed for the January 1, 2020 implementation date of the AUC program.

Medicaid Promoting Interoperability: Eligible Professionals (EPs) participating in the Medicaid Promoting Interoperability Program using eCQMs to report quality performance measures would be required to report a full calendar year in 2019 if having demonstrated meaningful use in the prior year. In 2021, the reporting period would be a continuous 90-day cycle. EPs would also be required to report on at least one outcome measure (or, if an applicable outcome measure is not available or relevant, one other high priority measure). Starting in 2021, CMS would use the same definition and set of high priority measures as used for the MIPS program.

Medicare Shared Savings Program Quality Measures: To align the quality measure sets for the accountable care organizations (ACOs) in the Medicare Shared Savings Program with the Meaningful Measures Initiatives, CMS proposes to reduce the number of quality measures required for reporting from 31 to 24. The proposed changes are detailed in Table 25 of the proposed rule.

Physician Self-Referral Law: In light of statutory provisions in the Bipartisan Budget Act of 2018, CMS is proposing to add a special rule that would essentially allow requirements for compensation arrangements to be satisfied by a collection of documents, including contemporaneous documents as evidence of the course of conduct between the parties.

Non-excepted Off-Campus Provider-Based Hospital Departments: CMS proposes to maintain the current payment rate for certain non-excepted off-campus provider-based departments (established after November 2, 2015) paid under the PFS, which is set at 40 percent of the hospital Outpatient Prospective Payment System (OPPS) rate.

Telehealth: CMS is proposing to add two new prolonged preventive codes to the list of covered telehealth services for beneficiaries with end-stage renal disease (ESRD) receiving home dialysis (G0513) and beneficiaries that have suffered an acute stroke (G0514).

Communication Technology-Based Services: Starting in 2019, CMS proposes to create new HCPCS to pay for virtual check-ins and remote evaluation of recorded video and/or imaging services. CMS also proposes separate payment for new Chronic Care Remote Physiologic Monitoring and Interprofessional Internet Consultation services.

QUALITY PAYMENT PROGRAM HIGHLIGHTS

Merit-based Incentive Payment System (MIPS) Proposals for Year 3

Eligible Clinicians: In Year 3 of the MIPS program, physical and occupational therapist, and clinical social workers and psychologists will be allowed to participate.

Low-Volume Threshold: The low-volume threshold will include a third criterion, in addition to receiving less than $90,000 in Part B allowed charges or treating 200 or fewer Medicare beneficiaries, clinicians would qualify for the low-volume threshold if they provide 200 or less in covered professional services under the PFS. Starting in Year 3, clinicians or groups that meet or exceed one or two of the low-volume threshold criterion would be able to opt-in to MIPS.
Virtual Groups: In general, policies for virtual group participation will remain the same, except the eligibility determination period will align with the first segment of data analysis under the MIPS program.

Performance Threshold: CMS proposes to increase the performance threshold from 15 points to 30 points and raise the threshold to earn an additional bonus for exception performance from at 80 points, to 70 points.

Payment Adjustment: As required by statute, the maximum payment adjustment will increase to +/- 7 percent, up from +/- 5 percent.

Quality Performance Category: CMS proposes to reweight the Quality performance category weight from 50 percent to 45 percent. Individuals and groups would be allowed to use multiple submission types per category (e.g., claims, EHRs, QCDRs, eCQM or MIPS CQMs) to submit MIPS performance data on at least six measures (or a measure set) including at least one outcome measure. If an applicable outcome measure is not available, report one other high priority measure. If fewer than six measures apply to the MIPS eligible clinician or group, report on each measure that is applicable.

Improvement Activities Performance Category: The performance category weight will remain at 15 percent of the total score. No changes are proposed for this category. CMS is proposing to add six new activities to the inventory of approved activities modify five existing activities and delete one activity.

Cost Performance Category: CMS proposes to increase the Cost performance category weight from 10 percent to 15 percent. The Total Per Capita Cost and Medicare Spending Per Beneficiary (MSPB) measures will remain applicable for the Cost performance category; however, eight episode-based measures would be added to the list of measures. For the procedural episode-based measures beginning with the 2019 performance period, the case minimum is 10, and for acute inpatient medical condition episode-based measures, the case minimum is 20.The improvement scoring component would not be factored into the Cost performance category score until the 2024 payment year/2022 performance year as required by the Bipartisan Budget Act of 2018.

Promoting Interoperability (formerly Advancing Care Information): The performance category weight will remain at 25 percent. CMS proposes to revise the total scoring method to eliminate the pass or fail base score requirement, as well as the separate performance and bonus scoring methodology. ECs will be required to use the 2015 Edition of certified EHR technology (CEHRT) that will include a single set of four objectives (and applicable measures). CMS also proposes to add the same two new measures to the e-Prescribing objective as proposed for the hospital Inpatient Prospective Payment System for fiscal year 2019.

Advanced Alternative Payment Model (APM) Proposals for Year 3

Revenue-based Nominal Amount Standard: CMS proposes to maintain and extend the 8 percent revenue-based nominal amount threshold through performance year 2024.

Minimum CEHRT Use: CMS is proposing to change the 50 percent threshold to require at least 75 percent of ECs in an APM entity use CEHRT in order to qualify as an Advanced APM. This proposal would also apply to Other Payer Advanced APMs.
MIPS Comparable Quality Measures: CMS also proposes to amend the Advanced APM criteria to specify that only one quality measure, not all, be comparable to MIPS quality measure criteria, including outcome measures, which must be valid and effective by 2020 for both Medicare and Other Payer Advanced APMs.

The proposed rule also includes a Request for Information (RFI) regarding promoting interoperability and electronic healthcare information exchange through possible revisions to the CMS patient health and safety requirements for hospitals and other Medicare and Medicaid participating providers and suppliers, and a RFI on price transparency to improve beneficiary access to provider and supplier charge information.

The official publication of the proposed rule will appear in the *Federal Register* on July 27, 2018. CMS will accept public comments on the proposed rule through September 10, 2018. AOA staff will continue to analyze the proposed rule and prepare written comments.

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