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On Nov. 1, 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) final rule.

This final rule makes payment and policy changes to the Quality Payment Program, starting Jan. 1. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in one of two ways:

- The Merit-based Incentive Payment System (MIPS).
- Advanced Alternative Payment Models (Advanced APMs).

As there is no vascular surgery-specific APMs (the Society for Vascular Surgery is working to develop one), most SVS members will continue to participate in the MIPS program this year. Changes for 2019 include:

MIPS Expanded to New Clinician Types

CMS is expanding the MIPS-eligible clinician definition to new clinician types including physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists and registered dietitians or nutrition professionals. If a practice or group employs any of these clinicians, the practices must report the various elements of the MIPS program and the clinicians will count toward the clinician total for being considered a small practice.

Low-Volume Threshold / Opt-In Policy

CMS added a third criterion for physicians to qualify for the low-volume threshold – providing 200 or fewer covered professional services to Part B patients. However, given the typical patient population age, most vascular surgeons will not be able to opt out of QPP.

A new CMS policy allows physicians to opt-in to participate in MIPS or create virtual groups and receive corresponding payment bonuses or penalties if they meet or exceed one or two — but not all — the low-volume threshold elements (i.e., 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). As QPP is a budget-neutral program, this could help increase the available funds for the bonus pool for SVS members.

Performance Threshold

CMS set the 2019 performance threshold for determining bonuses or penalties in 2021 at 30 points and the "exceptional performance" threshold at 75 points, a 100 percent increase from 2018's 15 points threshold. SVS members will need to participate in all elements of MIPS in 2019 to ensure they reach the 30-point threshold. In previous years, just participating in the Clinical Improvement Activities portion would have been enough to avoid a penalty.

Hospital-Based Scoring Option

This is the first year physicians may be scored for purposes of the MIPS quality and cost performance categories based on their attributed hospital's performance in the Hospital Value-Based Purchasing (VBP) Program. Facility-based scores for the 2019 performance period/2021 payment determination are based on the 12 measures included in the fiscal year 2020 Hospital VBP Program.

There is no election or opt-in required for facility-based scoring, nor is there an opt-out option. Instead, facility-based scoring automatically applies to MIPS-eligible clinicians and groups that qualify and would benefit by having the facility-based score. However, facility-based physicians may opt to participate through traditional MIPS and CMS will pick the best score to make a payment determination. This may be an option for employed vascular surgeons who believe they have more input in the hospital quality measure programs.

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 code used for inpatient (21) or emergency room (23). To be scored as a group, 75 percent or more of the National Provider Identifiers billing under the group's Tax Identification Number must be eligible for facility-based measurement as individuals, and the group must submit data in the Improvement Activity or Promoting Interoperability categories.

Promoting Interoperability (previously Advancing Care Information)

CMS has eliminated the base, performance and bonus scoring structure used in MIPS' first two years, instead scoring physicians on a 100-point scale at the individual measure level. CMS is also maintaining the hardship exceptions for this performance category.

However, CMS is requiring all physicians to use 2015 Certified EHR Technology (CEHRT) in 2019. Physicians who lack access to 2015 Edition CEHRT will be able to request a hardship exception.

CMS is adding two new measures — scored as bonus points in 2019 — to the e-Prescribing objective of the Promoting Interoperability Program: Query of Prescription Drug Monitoring Program and Verify Opioid Treatment Agreement.

New Reporting Option

A combination of data collection types for the quality performance category is allowed. 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 also is limiting the claims-based reporting option to individuals in small practices. However, CMS expands the claims-based reporting option to allow small group practices (15 or fewer eligible clinicians) to report via claims.

Data Completeness Criteria, Threshold and Scoring

CMS maintains that for a physician to be successful in reporting on a measure, he or she 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, he is eligible to receive three to

10 points based on performance compared to the benchmark. If a physician fails to meet the criteria, he is only eligible to receive one point. Small practices would continue to receive three points if they do not meet the criteria. The Quality Category will be weighted at 45 percent in 2019, a reduction of 5 percent.

Cost Category Weight Now 15 Percent of final Score

Despite protests from the SVS and many other medical organizations, CMS increased the cost category weight in MIPS to 15 percent. The final rule retains the two existing cost measures (Medicare Spending Per Beneficiary and Total Per Capita Cost of Care) with no changes and adds eight new episode-based measures in 2019, including one that SVS' Quality and Performance Measures Committee helped develop. All the measures include both Part A and Part B costs and are calculated from administrative claims.

Five of the new cost measures are tied to costs associated with a particular procedure (elective percutaneous coronary intervention, knee arthroplasty, revascularization for lower limb ischemia, routine cataract removal with IOL and screening colonoscopy). Three (intracranial hemorrhage or cerebral infarction, simple pneumonia with hospitalization and ST-Elevation Myocardial Infarction with PCI) involve costs associated with an acute inpatient medical condition. Procedural episodes are attributed to any physician who billed one of the "trigger" procedure codes, and any physician with at least 10 episodes in each measure is scored on it.

For more information on this final rule and to check your individual or practice enrollment status, visit www.qpp.cms.gov .

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