The Centers for Medicare & Medicaid Services (CMS) recently proposed changes to both Medicare physician payment and quality reporting program policies that would generally take effect Jan. 1, 2019. The proposed rule would change the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2019. MGMA will submit formal comments in response to the proposed rule and share them with members in the MGMA Washington Connection newsletter.

### Medical Practice Executive Insights

#### Key 2019 Medicare physician fee schedule (PFS) proposals
- CMS estimates the 2018 Medicare PFS conversion factor would be $36.0463 based on proposed policies. The Anesthesia conversion factor is estimated to be $22.2986.
- The agency takes a significant step to advance access to technology-based services and proposes to recognize and pay for additional communication services delivered remotely.
- CMS proposes to overhaul E/M coding and payment policies by collapsing levels 2-5 and paying a single, blended rate for office and outpatient E/M visits – approximately $134 for new patients and $92 for established patients.
- Aiming to reduce burden, CMS proposes substantial changes to E/M documentation and coding, including the option to document according to medical decision making only.

#### Key 2019 MIPS and APMs proposals
- Clinicians who fall below the low-volume threshold may be able to opt-in to the MIPS program and receive a payment adjustment.
- Cost measures would count toward 15% of the MIPS final score – an increase from 10% in 2018.
- Clinicians and groups would be required to use 2015-certified EHR technology.
- Group practices would be able to submit quality measure data using multiple data submission mechanisms, such as an EHR and registry.
- CMS proposes no new Advanced APMs. Only 160,000 to 215,000 eligible clinicians are expected to become qualifying APM participants, meaning they are exempt from MIPS and eligible for a 5% bonus. In aggregate, APM bonuses are expected to total about $600-$800 million for the 2021 payment year.
2019 PHYSICIAN FEE SCHEDULE (PFS) PROPOSALS

PHYSICIAN PAYMENT UPDATE

CMS estimates the 2019 Medicare PFS conversion factor will be $36.0463, which includes a 0.25% update as required by the Bipartisan Budget Act of 2018. The conversion factor update is offset by a -0.12 budget-neutrality adjustment. The Anesthesia conversion factor is estimated to be $22.2986.

MALPRACTICE RVUs

CMS is required to review, and if necessary, adjust the Malpractice (MP) RVUs by CY 2020. The agency is seeking specific feedback on how it might improve the way that specialties in the state-level raw filings data are cross-walked for categorization into CMS specialty codes, which are used to develop specialty-level risk factors and MP RVUs.

MODERNIZING PHYSICIAN PAYMENT THROUGH COMMUNICATION TECHNOLOGY-BASED SERVICES

CMS would go beyond routine telehealth coding updates of years past and take a significant step to advance virtual care and provide payment for associated services. Starting Jan. 1, 2019, CMS proposes to pay separately for the following newly-defined physician services furnished using communication technology:

- Brief non-face-to-face appointments (virtual check-ins) using HCPCS code GVCI1, and
- Evaluation of patient submitted images or video (“store and forward” technology) using HCPCS code GRAS1.

CMS is seeking comment on the description, coverage, and valuation of these services. In addition, CMS proposes to pay separately for new codes describing interprofessional internet consultation and expands on its policy to cover remote patient monitoring (RPM) services. CMS previously recognized RPM services as a new modality of technology-based services and began providing separate payment under CPT code 99091. CMS proposes to add new codes to describe when a qualified health professional remotely monitors physiological parameters such as weight, blood pressure, pulse oximetry, and respiratory rate using CPT codes 990X0, 990X1, and 994X9.

Significantly, CMS believes RPM services and virtual check-ins fall outside the scope of “Medicare telehealth services” defined in Section 1834(m) of the Social Security Act. This change in interpretation is important because Section 1834(m) establishes coverage restrictions on telehealth services that require a beneficiary to be located at a specific type of originating site located in a remote or rural location, among other limitations (83 FR 35723).

MEDICARE TELEHEALTH SERVICES

CMS proposes modifications to existing Medicare telehealth regulations required or permitted by the Bipartisan Budget Act of 2018, including added flexibilities for certain services related to end-stage renal disease home dialysis evaluation and acute stroke.
CMS also proposes to expand telehealth coverage for prolonged preventive services using Medicare HCPCS codes G0513 and G0514, but coverage would be subject to statutory geographic and originating site restrictions.

**PAYMENT RATES FOR NON-EXCEPTED, OFF-CAMPUS PROVIDER-BASED DEPARTMENTS**

Beginning in 2017, CMS pays for certain items and services furnished in off-campus, provider-based departments that did not bill Medicare prior to Nov. 2, 2015 or are otherwise not exempted under the PFS rather than the Outpatient Prospective Payment System (OPPS), as required by statute. Currently, CMS pays for these services under the PFS at a rate that is approximately 40% of the OPPS rate for the same code. The agency proposes to maintain the 40% relativity adjustment rate for 2019 and beyond. Physicians would continue to be reimbursed for the professional component of the service at the facility rate under the PFS. CMS believes this rate aligns overall payment amounts for services furnished in off-campus hospital departments with services furnished in physician practices and paid at the non-facility PFS rate.

**GLOBAL SURGERY DATA COLLECTION**

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to implement a process to collect data on postoperative visits and to use the data to assess the accuracy of global surgical package valuation. Beginning July 1, 2017, CMS required groups with 10 or more practitioners in nine states to use the no-pay CPT code 99024 to report postoperative visits for specified procedures. Of practitioners that met the criteria for reporting, only 45 percent participated. Reporting rates varied substantially by specialty. Among procedures performed by “robust reporters” of 99024, only 16 percent of 10-day global services and 87 percent of 90-day global services had one or more matched visits reported.

CMS is seeking comments pertaining to increased reporting compliance and whether visits are typically being performed in the 10-day global period. Also, the agency is seeking comment on whether it should mandate the usage of modifiers -54 “for surgical care only” and -55 “postoperative management only,” regardless of whether the transfer of care is formalized.

**EVALUATION AND MANAGEMENT (E/M) SERVICES**

*Proposed changes to E/M visit payment amounts*

CMS believes the system of 10 codes for new and established office visits is “outdated” and proposes to retain but revise and simplify the codes and their reimbursement by applying a single, blended payment rate for level 2 through 5 office visits.

<table>
<thead>
<tr>
<th>New patient office visits</th>
<th>CY 2018 Non-facility payment rate</th>
<th>CY 2018 Non-facility total RVUs</th>
<th>Proposed CY 2019 Non-facility payment rate</th>
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<tr>
<td>Est. patient office visits</td>
<td>CY 2018 Non-facility payment rate</td>
<td>CY 2018 Non-facility total RVUs</td>
<td>Proposed CY 2019 Non-facility payment rate</td>
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Other coding and payment proposals related to E/M visits

CMS proposes to:
- Reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E&M visit.
- Create an add-on payment of about $5 (0.15 RVUs) for primary care office visits via a new code GPC1X, visit complexity inherent to evaluation and management associated with primary medical care services.
- Create an add-on payment of about $12 (0.33 RVUs) for office visits performed by certain specialties via a new code GCG0X, visit complexity inherent to evaluation and management associated with: Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, or Urology.

CMS would also create a new prolonged service code as an add-on to any office visit lasting more than 30 minutes beyond the office visit (i.e., hour-long visits in total). The code GPRO1, prolonged evaluation and management or psychotherapy services(s) (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service), would have a payment rate of approximately $67 (1.85 RVUs).

Proposed documentation changes for office and outpatient E/M visits

Physicians would be allowed to choose one of the following methods of documentation:
1. 1995 or 1997 E/M guidelines for history, physical exam and medical decision making (i.e., the current framework for documentation);
2. Medical decision making only; or
3. Physician time spent face-to-face with patients.

Because payment rates for levels 2-5 E/M visits would be collapsed, CMS proposes a minimum documentation standard, requiring documentation to support the medical necessity of a level 2 E/M visit code. CMS assumes that physicians may continue to document according to the five E/M levels of codes for clinical, legal, operational and other purposes.

In addition, physicians would no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated. CMS would eliminate re-entry of information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner would only document that they reviewed and verified the information.
Proposed implementation date

The proposed implementation date for E/M changes is Jan. 1, 2019. CMS is seeking comment on whether the implementation should be delayed to Jan. 1, 2020.

TEACHING PHYSICIAN DOCUMENTATION REQUIREMENTS FOR E/M SERVICES

CMS proposes to allow the presence of the teaching physician during E/M services to be demonstrated by the notes in the medical records made by a physician, resident, or nurse. CMS also proposes to provide that the medical record must document the extent of the teaching physician’s participation in the review and direction of services furnished to each beneficiary, and that the extent of the teaching physician’s participation may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.

MEDICARE CLINICAL LABORATORY FEE SCHEDULE (CLFS) DATA COLLECTION

Starting Jan. 1, 2018, CMS implemented a new payment methodology for clinical laboratory testing paid under the CLFS using a market-based methodology, as required under the Protecting Access to Medicare Act (PAMA) of 2014. Payment under the revised CLFS is based on private payer pricing data collected and reported by “applicable laboratories,” including physician office laboratories (POLs) that meet certain revenue thresholds under their own national provider identifier (NPI). For most CLFS tests, PAMA requires that the data collection period, data reporting period, and payment rate update occur every three years. The next data collection period is set for Jan. 1 through June 30, 2019, the next data reporting period is set for Jan. 1 through Mar. 31, 2020, and the next CLFS update would occur on Jan. 1, 2021.

CMS acknowledges stakeholder concerns that the 2018 CLFS is based on data that is not representative of the laboratory community (i.e., that too few POLs and hospital outreach laboratories contributed data) and that POLs who reported data experienced significant burden.

In an effort to gain adequate representation from all sectors of the market, CMS proposes changes to the requirements that trigger data reporting obligations. Specifically, CMS proposes to revise the way Medicare Advantage (MA) payments are treated such that additional laboratories serving high populations of MA beneficiaries would be subject to reporting requirements. CMS also seeks comment on alternative approaches to defining the types of laboratories that must report data, including whether to increase or decrease the low volume threshold that exempts laboratories with low CLFS billings from reporting obligations. Additionally, CMS solicits suggestions on how to identify applicable laboratories, including whether to use an alternative identifier such as the CLIA certificate or Form 1450x bill type to define an applicable laboratory, instead of its current policy to use the NPI as an identifier.

PART B DRUGS

CMS proposes to reduce Medicare reimbursement rates for new drugs just coming onto the market. Generally, Medicare payment is tied to the Average Sales Price (ASP) for drugs, which includes discounts and rebates. Because there is no ASP data for new drugs, reimbursement during the first available quarter is tied to the Wholesale Acquisition Cost (WAC), which is based on the
manufacturer’s list price and does not include discounts and rebates. The ASP or WAC is then increased by 6% to reflect overhead costs (but after a 2% sequester cut is applied to Medicare’s share of the payment, the add-on is 4.3%). CMS proposes to reduce the new drug add-on to 3% (which would then be subject to the sequester cut) for a period of three months.

**APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES**

The AUC program requires ordering providers to consult with applicable AUC through a qualified clinical decision support mechanism for applicable imaging services. CMS previously delayed implementation of this program by including a voluntary reporting period, which started in July 2018 and runs through Dec. 2019. In 2020, the AUC program period will begin with an educational and operations testing period, during which CMS will continue to pay claims whether or not they correctly include AUC information.

CMS proposes to:
- Expand the definition of an applicable setting to include independent diagnostic testing facilities;
- Create significant hardship exceptions from AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- Establish the coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims; and
- Allow non-physicians, under the direction of an ordering professional, to consult with AUC when the consultation is not performed personally by the ordering professional.

CMS clarifies that AUC consultation information must be reported on all claims for an applicable imaging service (e.g., if separate, both the technical and professional claim must include the AUC information). CMS also invites comments on how to identify potential outliers that will be subject to prior authorization in future years.

**MEDICARE SHARED SAVINGS PROGRAM (MSSP) QUALITY MEASURES**

In an effort to reduce administrative burden, eliminate redundant measures, and focus the MSSP quality measure set on more outcomes and patient experience measures, CMS proposes to eliminate 10 measures and add one measure to the MSSP quality measure set beginning in 2019. The changes would result in 24 measures for which ACOs would be held accountable.

**2019 MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROPOSALS**

**NEW ELIGIBLE CLINICIANS (ECs)**

CMS would use its statutory authority to expand the EC definition to new clinician types including physical therapists, occupational therapists, clinical social workers, and clinical psychologists. CMS estimates approximately 650,000 clinicians will be MIPS ECs in 2019.
LOW-VOLUME THRESHOLD AND OPT-IN OPPORTUNITY

CMS proposes to add a third criterion for the low-volume threshold that excludes certain ECs and groups. The current threshold is $90,000 or less in Medicare Part B charges or 200 or fewer Medicare beneficiaries. For the 2019 performance period, CMS proposes to exclude ECs and groups that bill $90,000 or less in Medicare Part B charges, see 200 or fewer Medicare beneficiaries, or provide 200 or fewer covered professional services under the PFS. As Congress required in the MGMA-supported Bipartisan Budget Act of 2018, CMS proposes to remove Part B drugs from the low-volume threshold determinations.

CMS would allow ECs and group practices who exceed at least one of the three low volume threshold criteria to opt in to MIPS and be eligible for a corresponding payment bonus or penalty. The agency estimates 42,000 ECs will opt in to MIPS in 2019.

MIPS SCORE AND PAYMENT ADJUSTMENTS

ECs and group practices would continue to be scored 0-100 points in MIPS based on data in four performance categories: quality (45 points), cost (15 points), Promoting Interoperability (25 points) and improvement activities (15 points). CMS would maintain the bonus that adds up to five percentage points to the final MIPS score of ECs and groups who treat complex patients.

ECs and group practices would need to earn at least 30 out of a possible 100 points in 2019 to avoid a Medicare payment cut of up to 7% in 2021. This is an increase from the current threshold of 15 points. ECs and groups earning more than 30 points would be eligible for a positive payment adjustment in 2021. CMS estimates payment adjustments for the 2021 MIPS payment year would be approximately $372 million (both positive and negative adjustments for a budget neutral sum). In addition, $500 million would be available for ECs and group practices whose final score meets or exceeds the proposed exceptional performance threshold of 80 points.

As required by the Bipartisan Budget Act of 2018, MIPS payment adjustments would be applied only to the professional services payments of ECs and not to Part B drugs. Figure A, included below, displays CMS’ projected payment adjustment amounts based on MIPS proposals for 2019.
MIPS REPORTING PERIODS

ECs and groups would be required to report a minimum of 90 consecutive days of data for the Promoting Interoperability and improvement activity categories and 12 months of quality measure data in 2019. MGMA has been extremely critical of full-year quality data reporting and will continue to advocate for a 90-day minimum quality measure reporting period in 2019.

CERTIFIED EHR TECHNOLOGY (CEHRT) REQUIREMENTS

CMS proposes requiring use of 2015 Edition CEHRT for beginning in 2019. According to the Office of National Coordinator for Health IT, only 66% of MIPS ECs have 2015 CEHRT as of the first quarter of 2018.

MIPS CATEGORY: QUALITY (45% OF MIPS SCORE)

ECs and groups would continue to report six quality measures, including one outcome or high priority measure, for at least 60% of applicable patient encounters and a minimum of 20 cases. CMS would continue to evaluate each measure against a benchmark to determine a score. Each measure that meets the 60% data completeness threshold would continue to receive a minimum score of 3 points. If a group that reports the CAHPS for MIPS patient satisfaction survey measures cannot attain a sufficient sample size, CMS would hold the group harmless by reducing the quality score denominator by 10 points and scoring the CAHPS for MIPS measure at zero points.

In response to MGMA advocacy, CMS proposes to allow ECs and groups to report quality data using multiple data collection types, such as two qualified registries, except for the CMS Web Interface. The agency proposes to allow third party intermediaries to submit data to the CMS Web Interface in addition to groups, and on behalf of groups. CMS seeks comment about expanding the CMS Web Interface reporting option to groups consisting of 16 or more ECs in future years. Currently, the CMS Web Interface is available only to groups of 25 or more ECs.

CMS proposes to limit the claims-based reporting option to small practices (15 or fewer ECs); however the agency would allow small groups to report via claims at the group practice level. Previously, claims-based reporting was available only to those who reported at the individual level.

CMS proposes to add 10 new MIPS quality measures and remove 34 quality measures. The agency would maintain 2018 rules for “topped out” measures for 2019. This would include a finalized 4-year lifecycle for identifying and removing “topped out” measures from MIPS. In 2019, as in 2018, six “topped out” measures would continue to be assessed a maximum score of seven points.

CMS proposes to discontinue awarding high priority measure bonus points for CMS Web Interface reporters but would continue the high priority bonus for other reporting types if the EC or group practice reports on a minimum of one high-priority measure. CMS proposes to continue assigning bonus points for end-to-end electronic reporting. CMS proposes to move the small practice bonus applied to the MIPS final score in 2018 to the quality category score in 2019 and would add three bonus points for solo practitioners and group practices consisting of 15 or fewer ECs who submit at least one quality measure.
**MIPS CATEGORY: PROMOTING INTEROPERABILITY (25% OF MIPS SCORE)**

CMS renamed the “Advancing Care Information” category and is now referring to it as “Promoting Interoperability.” Promoting Interoperability would move away from base, performance, and bonus scoring and instead use performance-based scoring for each measure, except for those that require a yes/no response. ECs and groups would be required to report certain measures from four objectives and the scores for each measure would be added together to calculate the overall category score of up to 100 possible points. As part of this scoring reconfiguration, CMS proposes to remove the bonus for reporting certain improvement activities using CEHRT.

The agency proposes to add two new measures to the e-Prescribing objective: “Query of Prescription Drug Monitoring Program” and “Verify Opioid Treatment Agreement.” Both measures would be optional for 2019, although ECs that choose to report them would earn up to 5 bonus points for each measure. CMS proposes to remove six measures from the Promoting Interoperability category, including Request/accept Summary of Care and Clinical Information Reconciliation, which would be consolidated into one measure: Receive and Incorporate Health Information.

CMS would maintain the hardship exemption for Promoting Interoperability and expand the exemption to additional clinician types including physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

**MIPS CATEGORY: COST (15% OF MIPS SCORE)**

CMS proposes to increase the weight of the cost category from 10% to 15% of an EC’s or group’s final MIPS score in 2019. The cost category was originally scheduled to increase to 30% in 2019. However, the Bipartisan Budget Act of 2018, which was supported by MGMA, authorized CMS to weight cost between 10% and 30% through 2021.

CMS would continue to measure ECs and group practices on the Total Per Capita Cost and Medicare Spending Per Beneficiary measures. The agency would add eight episode-based measures listed below. The episode-based measures only include items and services that are related to the episode of care for a clinical condition or procedure, as opposed to including all services that are provided to a patient over a given period of time.

<table>
<thead>
<tr>
<th>Episode-based cost measures proposed for 2019 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Topic</td>
</tr>
<tr>
<td>Elective Outpatient</td>
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<tr>
<td>Percutaneous Coronary Intervention (PCI)</td>
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<tr>
<td>Knee Arthroplasty</td>
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<td>Revascularization for Lower Extremity Chronic</td>
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<tr>
<td>Critical Limb Ischemia</td>
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<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
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<tr>
<td>Screening/Surveillance Colonoscopy</td>
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<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
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<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
</tr>
</tbody>
</table>

**MIPS CATEGORY: IMPROVEMENT ACTIVITIES (15% OF MIPS SCORE)**

CMS proposes to add six new improvement activities, modify five improvement activities, and remove one improvement activity. CMS proposes to maintain an attestation reporting option and reduced reporting requirements for small practices.

**FACILITY-BASED MEASUREMENT**

CMS proposes a facility-based measurement option for ECs who perform at least 75% of their services in the hospital inpatient, on-campus outpatient or emergency department setting and groups with 75% or more such ECs. The agency would calculate the quality and cost scores for qualifying ECs and groups using a hospital’s performance in the Medicare Hospital Value-Based Purchasing program. To be measured as a group, a facility-based group must submit data in the improvement activities or Promoting Interoperability categories.

CMS proposes to automatically apply facility-based quality and cost scores to qualifying ECs and groups unless the agency receives another quality data submission for that EC or group and the combined quality and cost performances scores for the other submission results in a higher combined quality and cost score than the facility-based score.

**MEDICARE ADVANTAGE QUALIFYING PAYMENT ARRANGEMENT INCENTIVE (MAQI) DEMONSTRATION**

Currently, physician practices participating in value-based arrangements with MA plans may be required to simultaneously comply with MIPS to avoid a penalty on their Medicare Part B reimbursement. In response to MGMA advocacy urging reduced provider burden and recognition of practice participation in MA APMs, CMS proposes to exempt qualifying ECs and group practices from MIPS reporting requirements and payment adjustments under the MAQI demonstration. Note MAQI participants may earn the 5% bonus for Advanced APM qualified participants (QPs) only if
they separately participate in a Medicare or other payer Advanced APM. For more information, visit the CMS [MAQI webpage](#).

**2019 ALTERNATIVE PAYMENT MODELS (APMS) PROPOSALS**

**ADVANCED APM CRITERIA**

CMS proposes to amend the qualifications for Advanced APMs beginning in 2019. If finalized, APMs must require at least 75% of ECs in each APM Entity use CEHRT to document and communicate clinical care with patients and other health care professionals. This would be an increase from the current 50% threshold for CEHRT use.

Consistent with MGMA recommendations not to increase financial risk requirements for Advanced APMs, CMS proposes to maintain a revenue-based risk standard at 8% for an additional four years, through 2024.

**ALL-PAYER COMBINATION OPTION**

CMS proposes to allow participants in Other Payer APMs to describe their compliance with requirements that 50% of ECs use CEHRT, instead of mandating that APM payment contracts explicitly require use of CEHRT. For instance, commercial payers could document that CEHRT adoption rates within their network meet or exceed the relevant CEHRT use requirement. As recommended by MGMA, CMS proposes to certify Other Payer APMs as meeting CMS requirements for APMs for up to five years instead of requiring them to re-apply on an annual basis.

CMS 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 participants can meet Medicare and other payer APM participation thresholds using patient counts for one threshold and payment counts the other threshold, whichever is most advantageous to the EC or group practice.

**REQUESTS FOR INFORMATION (RFI)**

**RFI ON PRICE TRANSPARENCY: IMPROVING BENEFICIARY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION**

CMS requests information about potential actions to address beneficiary out-of-network access to care, surprise medical bills, and patient health plan literacy regarding coverage and benefits. CMS is specifically interested in comments regarding whether Medicare-enrolled physicians and group practices should be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service.

MGMA Government Affairs staff will continue to review these proposed regulation, and members who have questions should contact us at 202-293-3450 or govaff@mgma.org.