



Final 2019 Medicare Physician Payment and Quality Reporting Changes MGMA MEMBER-EXCLUSIVE ANALYSIS

On Nov. 1, 2018, the Centers for Medicare & Medicaid Services (CMS) finalized the 2019 Physician Fee Schedule (PFS), which makes changes to both Medicare physician payment and quality reporting program policies that generally take effect Jan. 1, 2019. The final rule updates the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) participation options and requirements for 2019. Members with questions regarding any of these policies should contact MGMA Government Affairs staff at 202-293-3450 or govaff@mgma.org.

Medical Practice Executive Insights

Key Takeaways 2019 Medicare PFS final rule

- The 2019 PFS conversion factor is set at \$36.0391. The Anesthesia conversion factor is \$22.2730.
- CMS finalizes payment for communication services delivered remotely.
- CMS defers changes to the coding and payment structure for E/M services until CY 2021 but implements several policies to reduce documentation burden starting in CY 2019.
- Starting in CY 2021, CMS implements changes to E/M payment policy by collapsing E/M office visit levels 2 through 4 for established and new patients, while maintaining payment for level 5 visits.

Key Takeaways 2019 MIPS and APMs final rule

- Clinicians and groups must use 2015-certified EHR technology when reporting for Promoting Interoperability and for participation in an Advanced APM.
- Cost measures count toward 15% of the MIPS final score – an increase from 10% in 2018.
- Group practices may submit quality measure data using multiple data submission mechanisms, such as an EHR and registry.
- Clinicians and groups who fall below the low-volume threshold can opt-in to the MIPS program and receive a payment adjustment.
- CMS announces no new Advanced APMs. Only 165,000 to 220,000 eligible clinicians are expected to become qualifying APM participants in 2019, meaning they are exempt from MIPS and eligible for a 5% bonus. In the aggregate, APM bonuses are expected to total about \$600-\$800 million for the 2021 payment year.

Final 2019 Physician Payment Policies

PHYSICIAN PAYMENT UPDATE

CMS estimates the CY 2019 Medicare PFS conversion factor at \$36.0391, which reflects adjustments based on budget neutrality and includes a 0.25% update as required by the Bipartisan Budget Act of 2018. CMS estimates the Anesthesia conversion factor will be \$22.2730. [Table 94](#) displays the estimated impact on total allowed charges by specialty resulting from the final payment changes.

TABLE 92: Calculation of the Final CY 2019 PFS Conversion Factor

CY 2018 Conversion Factor		35.9996
Statutory Update Factor	0.25 percent (1.0025)	
CY 2019 RVU Budget Neutrality Adjustment	-0.14 percent (0.9986)	
CY 2019 Conversion Factor		36.0391

MODERNIZING MEDICARE PHYSICIAN PAYMENT THROUGH COMMUNICATION TECHNOLOGY-BASED SERVICES

CMS modernizes the Medicare program by expanding reimbursement opportunities for communications-based services, including telephone interactions, patient-submitted photos, and inter-professional consultations starting in 2019. These new services are not considered “Medicare telehealth services” and therefore are not subject to the same coverage limitations or coding policies.

Section 1834(m) of the Social Security Act defines “Medicare telehealth services” as including professional consultations, office visits, and office psychiatric visits that are furnished using two-way, real-time interactive communication between an eligible beneficiary and practitioner. To be eligible, a beneficiary must be located in a rural geographic setting at a clinical facility (an “originating site”), such as a physician office, hospital, or skilled nursing facility. Section 1834(m)’s restrictive requirements have significantly impeded the adoption of Medicare telehealth services, and despite broad congressional support to expand Medicare beneficiary access to these services, Congress has yet to remove statutory barriers and CMS lacks regulatory authority to make changes.

In the 2019 PFS, CMS articulates a new interpretation of “Medicare telehealth services” by concluding this definition, and therefore associated statutory limitations, applies to a discrete set of services that are ordinarily defined, coded, and paid for as if they were furnished during an in-person encounter. CMS determined that communication technology-based services are inherently remote and rely on technology communications and are therefore outside the scope of Section 1834(m). This change in interpretation opens the door to new payment policies that recognize practitioners for the work they do outside of the traditional office visit and permits group practices to furnish communications technology-based services without meeting restrictive billing requirements that apply to “Medicare telehealth services.” MGMA is very supportive of this policy.

Virtual care codes

Starting Jan. 1, 2019, CMS will pay separately for two newly-defined physician services:

- *Brief non-face-to-face appointment (e.g., a virtual check-in), using HCPCS code G2012.* This code is intended to provide separate payment when a healthcare professional has a brief check-in with a beneficiary using communications technology like a telephone. To be separately reimbursable, the check-in cannot originate from a related E/M visit furnished within the

previous seven days nor lead to an in-person visit within 24 hours or soonest available appointment. The work RVU for this service is 0.25.

- *Evaluation of patient-submitted images or video and subsequent follow-up, using HCPCS code G2010.* The patient follow-up could take place via telephone, audio/video communication, secure text messaging, email or patient portal communication. Use of this code is subject to the same timeframe limitations as the virtual check-in code. The work RVU for this service is 0.18.

These codes are reportable by practitioners who independently bill Medicare for E/M visits and are limited to established patients. Beneficiaries must provide consent prior to each service and are responsible for any co-insurance amount owed.

Inter-professional consultations

CMS finalizes separate payment for two new codes that describe inter-professional internet/telephone consultations between a treating practitioner and a consulting practitioner (CPT codes 99451 and 99452) and unbundles existing CPT codes 99446, 99447, 99448, and 99449. Although these codes are intended to describe collaborative medical decision making among practitioners, beneficiaries are responsible for co-insurance amounts and practitioners must obtain and document prior consent.

Remote patient monitoring (RPM)

In the 2018 PFS, CMS finalized coverage for RPM services by unbundling and making separate payment for CPT code 99091. CMS expands on this policy through the 2019 PFS and will cover three new chronic care remote physiologic monitoring codes starting Jan. 1, 2019 (CPT codes 99453, 99454, and 99457). CMS declines to clarify the types of technology that will qualify for remote monitoring codes but intends to issue sub-regulatory guidance in the future.

MEDICARE TELEHEALTH SERVICES

CMS adds two new codes to the approved [list](#) of Medicare telehealth services starting in 2019 to describe prolonged preventive services (HCPCS codes G0513 and G0514). These services qualify as “Medicare telehealth services,” and therefore are subject to Section 1834(m)’s restrictions and administrative billing requirements, including use of the telehealth place of service (POS) code 02.

CMS finalizes modifications to existing Medicare telehealth regulations required or permitted by the Bipartisan Budget Act of 2018, including flexibilities for certain services related to end-stage renal disease home dialysis and acute stroke. Pursuant to the SUPPORT for Patients Act of 2018, CMS removes geographic requirements and adds a beneficiary’s home as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

EVALUATION AND MANAGEMENT (E/M) SERVICES

In the 2019 PFS, CMS proposed revisions to E/M documentation requirements intended to reduce physician burden starting Jan. 1, 2019. Additionally, CMS proposed coding and payment revisions for new and established patient office visits by applying a single blended payment rate for level 2 through 5 visits. CMS included additional E/M payment proposals, including the creation of multiple add-on codes for use during certain visits and a multiple procedure payment reduction (MPPR) for certain same-day services. MGMA and other stakeholder groups overwhelmingly [supported](#) efforts to reduce documentation burden, but opposed collapsing payment rates, opposed applying the MPPR to same-day visits, and expressed concern that add-on code proposals lacked sufficient clarity.

In general, the final rule reflects positive updates from the proposed rule that largely reflect MGMA comments to CMS. In the final rule, CMS aims to reduce documentation burden beginning Jan. 1,

2019, but delays changes to the coding and payment structure for E/M services until CY 2021, which allows MGMA and other stakeholders additional time to work with the agency to refine payment policies.

Changes to E/M visit documentation requirements in CY 2019

Effective Jan. 1, 2019, CMS finalizes the following changes to E/M documentation guidelines that were supported by MGMA:

- Practitioners are no longer required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated;
- Practitioners must only document that they reviewed and verified information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary; and
- Practitioners no longer need to document medical necessity of furnishing visits in the home rather than office

Changes to E/M visit payment and coding policies starting in CY 2021

Effective Jan. 1, 2021, practitioners will have additional flexibility in documenting E/M office level visits 2 through 5 and may choose one of the following methods of documentation:

- The existing framework of 1995 or 1997 E/M guidelines for history, physical exam, and medical decision making (MDM);
- MDM only; and
- Physician time spent face-to-face with patients.

When documenting for level 2 through 4 visits using the current framework or MDM only, CMS will require documentation that supports a level 2 visit only.

For 2021, CMS intends to consolidate payment rates E/M office visits for levels 2 through 4 while maintaining separate payment for level 5 visits to account for care provided to the most complex patients. In addition, CMS intends to implement three new add-on codes for: primary care services, inherently complex non-procedural specialty E/M visits, and extended visits. The codes are intended to reflect the additional resources inherent in furnishing certain E/M services and not accounted for in the valuation of base E/M codes. CMS clarifies that use of these codes is not specialty-specific, and the agency does not envision the codes will require additional documentation burden.

Consistent with MGMA advocacy, CMS did not finalize the proposal to apply the MPPR when E/M office/outpatient visits are furnished on the same day as procedures.

TABLE 24B: Comparison of 2018 and 2021 Estimated National Payment Amounts for Visits

	Complexity level	CY 2018 non-facility payment	CY 2021 non-facility payment	Visit with primary or specialized care add-on code*	Visit with extended services code
New Patient	Level 2	\$76	\$130	\$143	\$197
	Level 3	\$110			
	Level 4	\$167			
	Level 5	\$211			
Established Patient	Level 2	\$45	\$90	\$103	\$157
	Level 3	\$74			
	Level 4	\$109			
	Level 5	\$148			

*In cases where one could bill both the primary and specialized care add-on, there would be an additional \$13.

TEACHING PHYSICIAN DOCUMENTATION REQUIREMENTS FOR E/M SERVICES

CMS finalizes the proposed policy to allow the presence and participation of the teaching physician during E/M office visits to be demonstrated by notes in the medical record made by a physician, resident, or nurse.

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

CMS continues site-neutral payment policies under Section 603 of the Bipartisan Budget Act of 2015. In CY 2019, CMS continues to allow the nonexcepted off-campus provider-based departments of hospitals to bill for nonexcepted services on the institutional claim and maintains the CY 2018 payment rate for nonexcepted services of 40% of the Outpatient Prospective Payment System (OPPS). Physicians will continue to be reimbursed for the professional component of the service at the facility rate under the PFS.

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 Jan. 1 through June 30, 2019, followed by the next data reporting period of Jan. 1 through Mar. 31, 2020, with the next CLFS update occurring on Jan. 1, 2021.

Effective 2019, CMS amends its definition of “applicable laboratory” to capture more pricing data from a wider segment of the laboratory community. Specifically, CMS revises the way Medicare Advantage (MA) payments are treated such that additional laboratories serving high populations of MA beneficiaries would be subject to reporting requirements. However, CMS states that it expects minimal impact on CLFS rates as a result of this change. Additionally, CMS uses a second identifier, the Form 1450x bill type, to define an applicable laboratory, in addition to the current policy to use the NPI as an identifier.

It is unclear what impact finalized CLFS policies will have on the number of POLs that have to report. MGMA has repeatedly expressed concerns to CMS regarding its implementation of PAMA, which include that the agency must not finalize policies that further burden POLs.

PART B DRUGS

The rule revises the reimbursement rate for new Medicare Part B drugs to reflect the wholesale acquisition cost plus 3% instead of the current 6% (before the required sequester reduction). This change only impacts the reimbursement rate during the first three months the drug is on the market; after that period, Part B drugs are paid according to the average sales price (ASP) plus 6%. The final rule does not impact ASP payment policy.

APPROPRIATE USE CRITERIA (AUC) FOR ADVANCED DIAGNOSTIC IMAGING SERVICES

Included in PAMA, 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 in favor of 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.

The rule finalizes the following:

- Expansion of the definition of an applicable setting to include independent diagnostic testing facilities;
- Creation of significant hardship exceptions from AUC requirements that are specific to the AUC program and independent of other Medicare programs;
- Establishment of the reporting methodology, to include G-codes and modifiers, to report the required AUC information on Medicare claims; and
- Allowance of 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

To reduce administrative burden, eliminate redundant measures, and focus the MSSP quality measure set on more outcomes and patient experience measures, CMS eliminates 10 measures and adds one measure to the MSSP quality measure set beginning in 2019. The changes result in 23 measures for which ACOs will be accountable.

Final 2019 MIPS Policies

NEW ELIGIBLE CLINICIANS (ECs)

CMS expands the EC definition to include new clinician types including physical therapists, occupational therapists, clinical social workers, qualified speech-language pathologists, audiologists, registered dietitians/nutritional professionals, and clinical psychologists. CMS estimates approximately 798,000 clinicians will be MIPS ECs in 2019.

LOW-VOLUME THRESHOLD AND OPT-IN OPPORTUNITY

CMS adds a third criterion for the low-volume threshold that excludes certain ECs and groups from MIPS. The current threshold is \$90,000 or less in Medicare Part B charges or 200 or fewer Medicare beneficiaries. For the 2019 performance period, the final rule excludes ECs and groups that bill \$90,000 or less in Medicare Part B charges, see's 200 or fewer Medicare beneficiaries, or provides 200 or fewer covered professional services under the PFS. As required by Congress in the MGMA-supported Bipartisan Budget Act of 2018, CMS removes Part B drugs from low-volume threshold determinations.

CMS now allows ECs and group practices who exceed one or two of the three low-volume threshold criteria to voluntarily opt-in to MIPS to become eligible for a corresponding payment bonus or penalty. ECs and groups wishing to opt-in should elect to do so using the QPP portal; CMS notes this decision is irrevocable.

MIPS SCORE AND PAYMENT ADJUSTMENTS

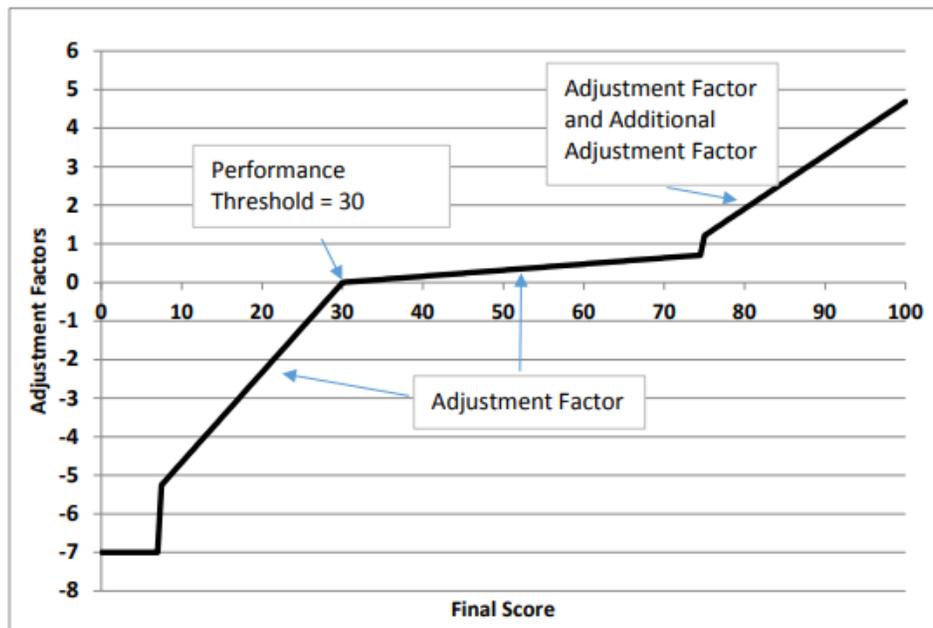
ECs and group practices will continue to be scored 0-100 points in MIPS based on data in four performance categories: quality (45 points), Promoting Interoperability (25 points), cost (15 points),

and improvement activities (15 points). CMS maintains the bonus that adds up to five points to the final MIPS score for ECs and groups who treat complex patients.

ECs and group practices must earn at least 30 points in 2019 to avoid a Medicare payment penalty 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 will be eligible for a positive payment adjustment in 2021. CMS estimates payment adjustments for the 2021 MIPS payment year will be approximately \$390 million (both positive and negative adjustments for a budget neutral sum). In addition, as it was in 2018, \$500 million will be available for ECs and group practices whose final score meets or exceeds the proposed exceptional performance threshold of 75 points in 2019, an increase from 70 points in 2018.

As required by the Bipartisan Budget Act of 2018, MIPS payment adjustments will apply only to the professional services payments of ECs and not to Part B drugs. Figure 3, included below, displays CMS' projected payment adjustment amounts based on MIPS proposals for 2019.

FIGURE 3: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Performance Threshold and Additional Performance Threshold for the 2021 MIPS Payment Year



MIPS REPORTING PERIODS

ECs and groups must 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 critical of full-year quality data reporting.

MIPS CATEGORY: QUALITY (45% OF MIPS SCORE)

ECs and groups must still report at least 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 continues to evaluate each measure against a benchmark to determine a score. Each measure that meets the 60% data completeness threshold will 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 will 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 permits ECs and groups to report quality data using multiple data collection types, such as two qualified registries, except for the CMS Web Interface.

CMS limits the claims-based reporting option to small practices (15 or fewer ECs); however, the agency allows 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.

The rule adds 10 new MIPS quality measures, removes 34 quality measures, and maintains the 2018 rules for “topped out” measures. This includes 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 continues to assign bonus points for reporting additional high priority measures beyond the one that is required but is discontinuing the bonus for reporters using CMS Web Interface. CMS continues assigning bonus points for end-to-end electronic reporting. CMS moves the small practice bonus applied to the MIPS final score in 2018 to the quality category score in 2019 and adds three bonus points for solo practitioners and group practices consisting of 15 or fewer ECs who submit at least one quality measure.

CERTIFIED EHR TECHNOLOGY (CEHRT) REQUIREMENTS

2015 Edition CEHRT is now required beginning in 2019. According to the Office of National Coordinator for Health IT, only 66% of MIPS ECs had 2015 CEHRT as of the first quarter of 2018. MGMA opposed this new mandate. CMS has added a hardship exception for ECs whose vendors will not be producing a 2015 Edition CEHRT version.

MIPS CATEGORY: PROMOTING INTEROPERABILITY (25% OF MIPS SCORE)

CMS renames the “Advancing Care Information” category and now refers to it as “Promoting Interoperability.” Promoting Interoperability moves 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 are required to report certain measures from four objectives and the scores for each measure will be added together to calculate the overall category score of up to 100 possible points. As part of this scoring reconfiguration, CMS has finalized removing the bonus for reporting certain improvement activities using CEHRT.

The agency adds two new measures to the e-Prescribing objective: “Query of Prescription Drug Monitoring Program” and “Verify Opioid Treatment Agreement.” Both measures will be optional for 2019 and 2020, although ECs that choose to report them will earn up to 5 bonus points for each measure. CMS consolidated two former measures into one new measure, Receive and Incorporate Health Information, and there is a new exclusion from this measure when a physician’s EHR cannot receive or use electronic health information

CMS maintains the hardship exemption for Promoting Interoperability and expand the exemption to include the newly-added clinician types such as physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

Final Scoring Methodology for the MIPS 2019 Performance Year		
Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10
	<i>Bonus:</i> Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
	<i>Bonus:</i> Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40
Public Health and Clinical Data Exchange	<p><u>Report to two different public health agencies or clinical data registries for any of the following:</u></p> <ul style="list-style-type: none"> • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data registry Reporting • Syndromic Surveillance Reporting 	10

MIPS CATEGORY: COST (15% OF MIPS SCORE)

CMS increases 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 the 2021 performance year.

CMS continues to measure ECs and group practices on the Total Per Capita Cost and Medicare Spending Per Beneficiary measures. The agency also adds eight episode-based measures listed below. The episode-based measures only include items and services 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.

Episode-based cost measures for 2019 and beyond			
Measure Topic	Measure Type	Case minimum	Attribution methodology
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	10	Attributed to each EC who renders a trigger service that is identified by CPT codes
Knee Arthroplasty	Procedural	10	Attributed to each EC who renders a trigger service that is identified by CPT codes

Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	10	Attributed to each EC who renders a trigger service that is identified by CPT codes
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	10	Attributed to each EC who renders a trigger service that is identified by CPT codes
Screening/Surveillance Colonoscopy	Procedural	10	Attributed to each EC who renders a trigger service that is identified by CPT codes
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	20	Attributed to each EC who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E/M claim lines
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	20	Attributed to each EC who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E/M claim lines
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	20	Attributed to each EC who bills inpatient E/M claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E/M claim lines

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

As MGMA advocated, CMS maintains attestation as a reporting mechanism for improvement activities and a 90-day performance period. CMS finalizes six new improvement activities, modifies five, and removes one improvement activity.

FACILITY-BASED MEASUREMENT

CMS finalizes 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 will calculate the quality and cost scores for qualifying ECs and groups using a hospital's performance in the Medicare Hospital Value-Based Purchasing program.

CMS will 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 from the other submission results in higher combined scores relative to 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 finalizes rules 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](#).

Final 2019 APM Policies

ADVANCED APM CRITERIA

Beginning in 2019, the percentage of an Advanced APM participating physicians using CEHRT increases to 75% from 50%. Consistent with MGMA recommendations not to increase financial risk requirements for Advanced APMs, CMS maintains a revenue-based risk standard at 8% for an additional four years, through 2024.

ALL-PAYER COMBINATION OPTION

As recommended by MGMA, CMS will 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.

Beginning in 2019, CMS allows All Payer APMs to request QP determinations be performed at the TIN level when all ECs are included in a single APM Entity and have reassigned their billing rights to the TIN. 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.

MGMA Government Affairs staff will continue to review and evaluate these final rules and encourage members who have questions to contact us at 202-293-3450 or govaff@mgma.org.