Part B Insider (Multispecialty) Coding Alert

Part B Payment: CMS Overhauls QPP's Promoting Interoperability ... Again

Plus: 2015 Edition CEHRT is now a reality for 2019.

If your head is spinning from all the deregulation over the last year, it looks like that was only CMS's first act. Recent policy changes upend the Quality Payment Program (QPP) tech component, Promoting Interoperability (PI), leaving Part B providers with a lot on their plates starting January 1.

Context: CMS released its Medicare Physician Fee Schedule final rule for CY 2019, which was published in the Federal Register on Nov. 23. The 2,378-page policy manifesto included a section on QPP Year 3 and a significant revamp of the Merit-Based Incentive Payment System (MIPS) PI performance category. The 2019 changes aim to reduce burdens, utilizing ideologies from the agency's favorite initiatives, Meaningful Measures and Patients Over Paperwork.

Reminder: PI used to be called Advancing Care Information (ACI), until the agency rebranded the tech component in May (see Part B Insider, Vol. 19, No. 6).

Check Out What's Ahead

One of the biggest impacts concerns an overhaul of the MIPS PI scoring methodology, suggests **Mike Schmidt,** Vice President of Client Success and Regulatory Affairs for Eye Care Leaders in Charlotte, North Carolina.

New score system: CMS is getting rid of the "base, performance, and bonus scores" and replacing them with a "performance-based scoring at the individual measure-level," notes the QPP Year 3 fact sheet. In 2019, every measure will be determined by scores from a MIPS-eligible clinician's performance for that measure based on the submission of a numerator or denominator, or a 'yes or no' submission, where applicable," the fact sheet indicates. It's vague how that will work, but "the scores for each of the individual measures would be added together to calculate the score of up to 100 possible points. If exclusions are claimed the points for measures will be reallocated to other measures," CMS says.

The policy change will "make it significantly harder to get a perfect score," Schmidt says, adding that "CMS tries to justify these changes in the name of 'flexibility.'"

According to the fee schedule, CMS went ahead with the elimination of the base, performance, and bonus scores to provide "flexibility... offering clinicians multiple measures to choose from" despite confusing some clinicians in the process, the final rule says. "In other words, CMS admits that they intentionally removed flexibility," underscores Schmidt. "But, then in their response to public comments criticizing the changes, they defend the new scoring time and again by claiming that it provides 'flexibility.'"

CEHRT requirement: For CY 2019, MIPS-eligible clinicians will still have a 90-day minimum reporting period, but they will now be required to use 2015 Editions of Certified EHR Technology (CEHRT). However, the EHR policy may be tough for practices to implement with only a five-week window for the upgrade. "How in the world are clinicians supposed to get updated software in time?" asks Schmidt. "How long does CMS believe it takes an EHR vendor to take their new specifications, translate them into detailed software requirements, design the software changes, program the new measures, test them as part of their Quality Management System, validate them with clients, and then implement them across all their clients?"

Objectives and measures: For QPP Year 3, eligible Part B providers have the following to look forward to:

- **Four objectives:** In 2019, provider objectives will include e-Prescribing, Health Information Exchange,

Provider to Patient Exchange, and Public Health and Clinical Data Exchange. Practitioners will be "required to report certain measur…es from each of the four objectives, unless an exclusion is claimed," advises CMS.

- **CEHRT measures:** In addition to the four other objectives' requirements, a measures set and objective will be added for the 2015 Edition CEHRT, notes the fact sheet.
- **Opioid add-in:** Under the e-Prescribing section, MIPS clinicians will now have two new objectives: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement.
- **Risk analysis:** According to CMS, a risk analysis measure will still be required, but it will no longer factor into the score. Instead of giving accolades to practices for completing this measure, the agency - citing the HIPAA Security Rule regulations - believes that every MIPS clinician should be doing this anyway "to comply with HIPAA's administrative, physical, and technical safeguards," the final rule stresses.

Caveat: Some of the measures have been rebranded and aren't fully fleshed out, which may cause issues down the line. One problem is the less-than-stellar final rule policy guidance, implies Schmidt, pointing out the agency's interpretation of the term "transition of care" as an example. For the measure, "Support Electronic Referral Loops by Sending Health Information" (formerly named the easier-to-understand "Send a Summary of Care"), "CMS 'clarifies' that a transition of care or referral back to the referring provider should be included in the denominator of this measure, at first seemingly indicating, that every patient referred is thus automatically considered to be transitioned back," he explains.

Schmidt continues, "However, this new CMS guidance really doesn't provide more clarity, since it depends on the definition of 'transition of care.'" In the past, the agency "included the following statement in its definition of transition of care: 'At minimum this includes all transitions of care and referrals that are ordered by the MIPS-eligible clinician,'" he adds.

"It implies that only if the specialist orders a transition of care or referral back to the referring physician must the patient be counted in the denominator of this measure. This is sure to cause a lot of confusion moving forward," exclaims Schmidt.

Resources: Read the final rule at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf.

Review the QPP Year 3 fact sheet at www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Year-3-Final-Rule-overview-fact-sheet.pdf.