# MACRA 2019 Update: What to Know

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On November 1, 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2019 Medicare Physician Fee Schedule.[1] This document includes policy information for the third performance year of the CMS Quality Payment Program (QPP). CMS created the QPP in response to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Congress subsequently made significant modifications to the MACRA legislation via the Bipartisan Budget Act of 2018 that became public law on February 9, 2018.

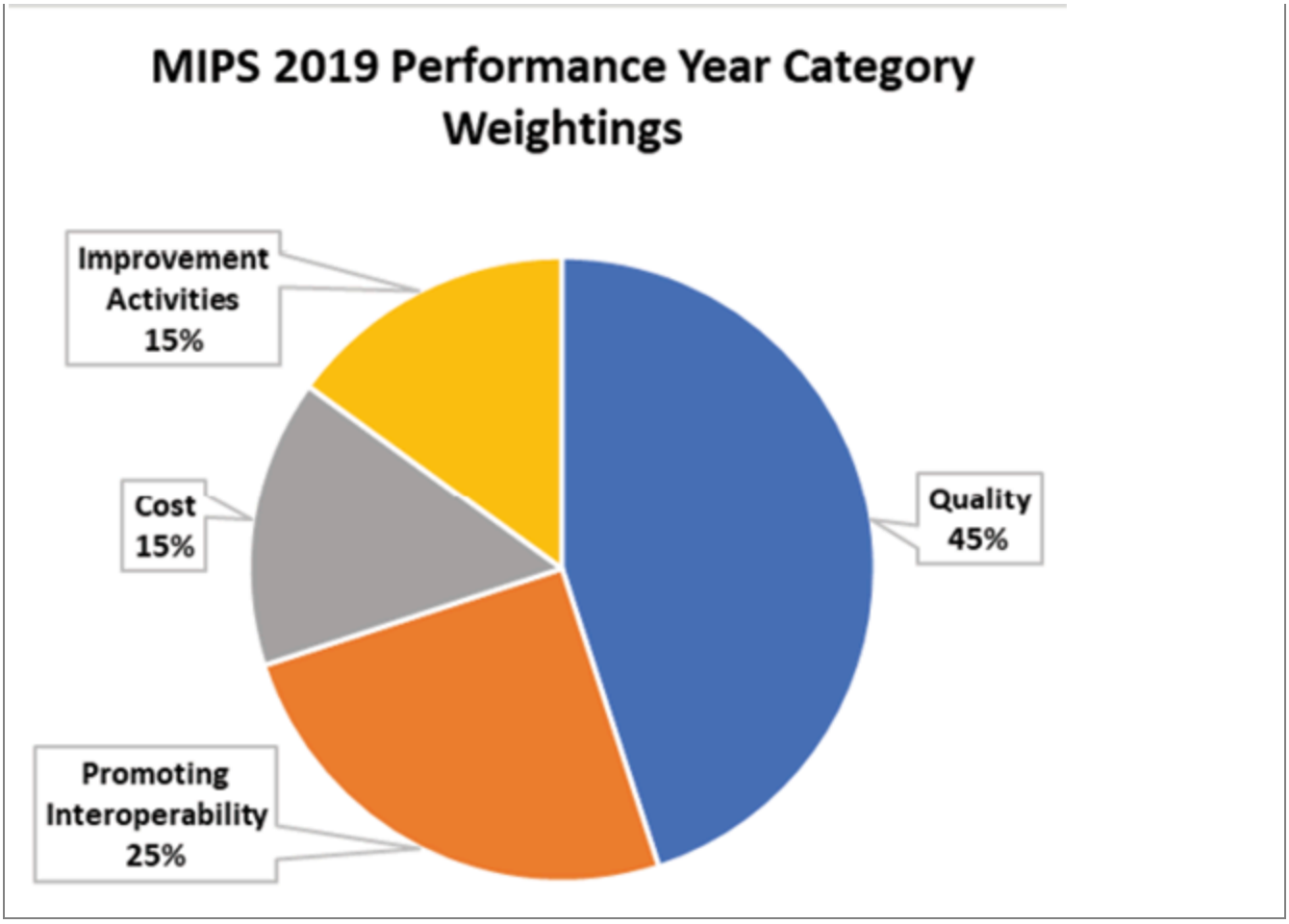
The QPP has two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). This article will provide an overview of impactful changes to the QPP for 2019 and serves as a more detailed version of an article on this topic that was initially published on the Journal of AHIMA website on December 6, 2018.

## MIPS 2019 Performance Year Changes

MIPS has four performance categories: quality, cost, Promoting Interoperability, and improvement activities. Performance in each of these categories is used to determine the final MIPS score, which can range from 0 to 100 points. The final MIPS score is used to determine payment adjustments in a corresponding payment year that occurs two years after the performance year. For example, performance in the MIPS in 2019 will determine payment adjustments in 2021.

The Bipartisan Budget Act of 2018 allowed CMS to gradually increase the weighting (i.e., relative percentage) of the MIPS cost category in performance years 2019, 2020, and 2021. Without this change, the cost category's weighting would have risen to 30 percent in the 2019 performance year. The cost category weighting will gradually increase over the next three years until reaching 30 points by the 2022 performance year. As shown in Figure 1, the cost category will have a weighting of 15 percent in the 2019 performance year, an increase from 10 percent in 2018. The quality category's weighting has been reduced from 50 percent in 2018 to 45 percent.

**Figure 1: MIPS Category Weighting Scenarios in 2019**




The performance periods for each MIPS category have remained the same: 90 continuous days for the Promoting Interoperability and improvement activities categories, and 365 days for the quality and cost categories.

### Expansion of MIPS-Eligible Clinician Types

CMS has exercised its option under the MACRA legislation to increase the number of clinician types eligible for MIPS in the third year of the program (2019). The current and newly-added clinician types are shown in Table 1 below.

### Table 1: Eligible Clinician Types by Performance Year

| MIPS Eligible Clinicians in 2017-2018 | MIPS Eligible Clinicians Added in 2019 |
|---|---|
| Physicians | Physical therapists |
| Physician assistants | Occupational therapists |
| Nurse practitioners | Qualified speech-language pathologists |
| Clinical nurse specialists | Qualified audiologists |

| | |
|---|---|
| Certified nurse anesthetists | Clinical psychologists |
| | Registered dieticians/nutrition professionals |

Starting on January 1, 2019, these additional clinicians become MIPS-eligible whether reporting as individuals or as part of a group—unless they meet the exclusion criteria described below. If they report as individuals or as a group made up of only the clinician types newly eligible in 2019, then their score will be determined by the performance in the quality and improvement activity categories alone (i.e., they will not be scored on performance in the Promoting Interoperability or cost categories). For the new clinician types shown in Table 1, quality will have a weighting of 70 percent and improvement activities will have a weighting of 30 percent. Meeting maximum requirements for improvement activities alone would allow these clinician types to avoid negative payment adjustments in 2021 as they will have met the 30-point threshold.

However, it is important to note that a high percentage of newly-added clinician types in 2019 will report as part of a group that includes physicians. When reporting as a group that includes one or more eligible physicians, data from all members of the group in all four MIPS performance categories is used to determine the final MIPS score. Some practices may wish to provide additional training to clinicians that represent one of the newly-added clinician types if their activities involve performance in the Promoting Interoperability category (i.e., the "Provide Patients Electronic Access to Their Health Information" Promoting Interoperability measure, described below).

## MIPS Exclusion Criteria

The two threshold criteria for exclusion from the MIPS that are based on allowed charges and patient volumes have not changed. However, CMS has added a third exclusion criteria based on service volumes. In the 2019 performance year CMS will exclude otherwise eligible clinicians and groups from the MIPS if they meet any one of the following criteria:

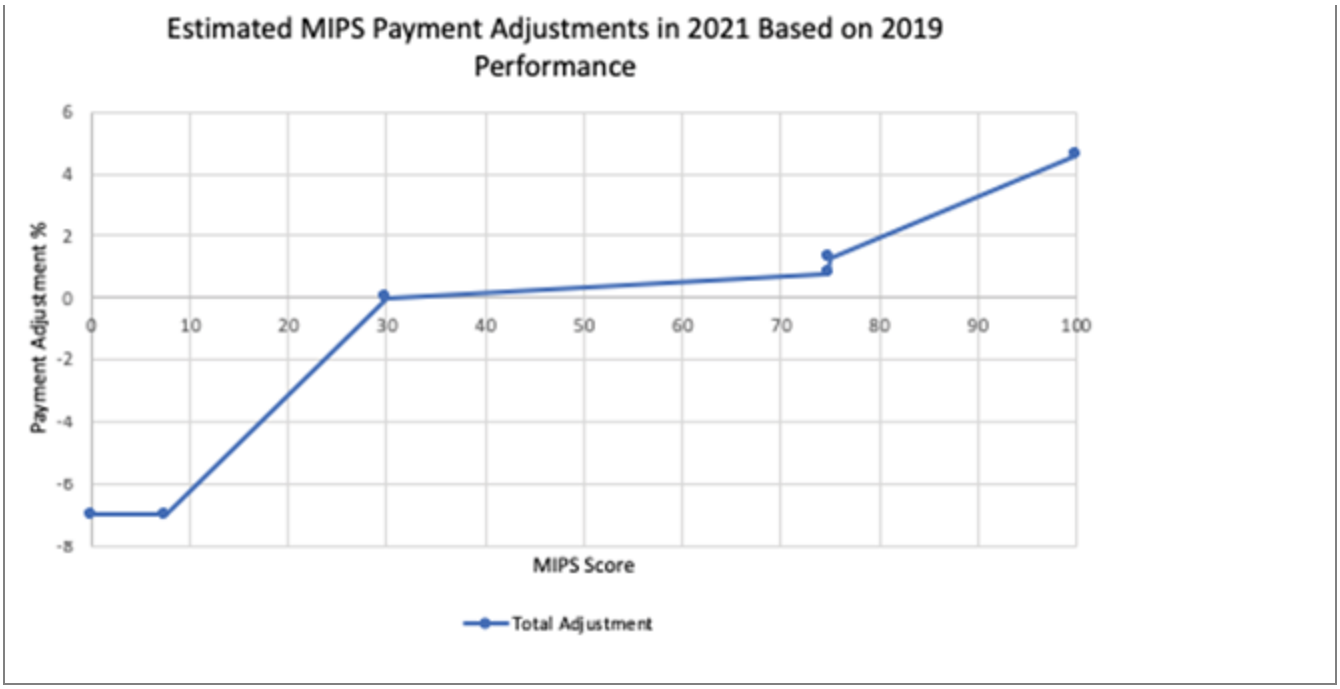
- ≤ $90,000 in allowed Part B charges
- ≤ 200 Part B beneficiaries seen during the determination period
- ≤ 200 in allowed Part B professional services

As noted above, the third criteria, ≤ 200 allowed Part B services, is new in 2019. It will reduce the threshold needed to participate in MIPS as a high percentage of eligible Medicare Part B beneficiaries will receive more than one professional service (i.e., evaluation and management (E&M) services) during a calendar year. CMS has given individual clinicians and groups the option of participating in MIPS if any one or two of the above thresholds are exceeded, but not all three. CMS made this change to allow a subset of clinicians that wanted to participate in the MIPS the opportunity to become MIPS-eligible. Clinicians new to Medicare and Qualifying Advanced APM Participants (QPs) are also excluded, as they have been in the past.

## MIPS Performance Threshold

The MIPS performance threshold for neutral payment adjustments has been raised to 30 points for 2019 (see Figure 2). Scores above the payment threshold receive positive payment adjustments and scores below the payment threshold receive negative payment adjustments in 2021, the corresponding payment year. The Bipartisan Budget Act of 2018 allows CMS to determine the performance thresholds in performance years 2019-2021. Starting in the 2022 performance year the threshold will be determined by the mean or median scores of all MIPS-eligible practices.

### Figure 2: Estimated MIPS Payment Adjustments in the 2021 Payment Year[2]




CMS has set the "Additional Performance Threshold" for exceptional performance at 75 points in 2019. Practices that score 75 points or higher will receive a portion of a $500 million exceptional performance fund. There is an additional positive payment adjustment of 0.5 percent for practices that achieve a score of 75 points. From here the adjustment will gradually increase on a linear scale (based on the MIPS score) between 75 and 100 points, as shown in Figure 2 above.

## EHR Certification Requirements in 2019

In 2018, practices could use electronic health record (EHR) systems certified using 2014 or 2015 Edition criteria. In 2019, all practices must use Certified EHR Technology (CEHRT) that was certified using the 2015 Edition requirements to receive a score in the Promoting Interoperability performance category. A bonus associated with use of 2015 Edition CEHRT in 2018 has been eliminated in 2019. As noted previously, the reporting period for the Promoting Interoperability performance category is a minimum of 90 continuous days, allowing practices time in 2019 to upgrade or install EHRs as needed.

## MIPS Promoting Interoperability Performance Category in 2019

CMS made what it described as an "overhaul" of the Promoting Interoperability performance category of MIPS (formerly known as Advancing Care Information) in the 2019 Medicare Physician Fee Schedule Final Rule. Their stated goal was to emphasize support for interoperability and patient access, while better aligning the ambulatory and hospital Promoting Interoperability requirements.

The weighting of this MIPS category remains at 25 percent. CMS made substantive modifications to the objectives, measures, and scoring methodology for the 2019 performance year. The number of objectives were reduced, some measures were combined, and two new measures were added: "Query of Prescription Drug Monitoring Program" and "Verify Opioid Treatment Agreement" (see Table 3 below). The two new measures have been made optional in 2019 to reduce the burden on health IT vendors and individuals who manage performance of the Promoting Interoperability measure at their organizations. Several of the 2019 Promoting Interoperability measures have exclusions. When this occurs, the potential points (i.e., denominator value) from an excluded measure are shifted to other measures.

The previous mandatory base measure scoring methodology has been eliminated. In 2018, practices using 2015 Edition CEHRT earned 50 of the maximum 100 points in the Promoting Interoperability category for performing a security risk analysis and meeting minimal volume (i.e., single episode) requirements for four additional measures. Practices were required to meet the minimum requirements for each base measure in order to receive a score greater than zero points in the Promoting Interoperability performance category (see Table 2 below).

## Table 2: 2018 Promoting Interoperability Objectives, Measures, and Scoring (Non-Transitional)[3]

| Objective | Measure | Maximum Points |
|---|---|---|
| Protect Patient Health Information | Security Risk Analysis* | 0 |
| Electronic Prescribing | e-Prescribing* | 0 |
| Patient Electronic Access | Provide Patient Access* | 10 |
| | Patient-Specific Education | 10 |
| Coordination of Care Through Patient Engagement | View, Download, or Transmit (VDT) | 10 |
| | Secure Messaging | 10 |
| | Patient-Generated Health Data | 10 |
| Health Information Exchange | Send a Summary of Care* | 10 |
| | Request/Accept Summary of Care* | 10 |
| | Clinical Information Reconciliation | 10 |
| Public Health and Clinical Data Registry Reporting | Immunization Registry Reporting | 0 or 10 |
| | Syndromic Surveillance Reporting | 0 or 10 |
| | Electronic Case Reporting | 0 or 10 |
| | Public Health Registry Reporting | 0 or 10 |
| | Clinical Data Registry Reporting | 0 or 10 |

| BONUS Points | |
|---|---|
| Report to one or more additional public health agencies/clinical data registries beyond the one identified for the performance score | 5 |
| Report using only 2015 Edition CEHRT | 10 |
| Report specified improvement activities that required the use of certified EHR technology | 10 |

** Base Measures Note: Maximum performance category points excluding bonus points = 90 points; Points are added to mandatory base measure score of 50 points*

In 2019 practices, all measures except for the registry measures are performance-based (see Table 3 below). The total score in each measure is summated to achieve the Promoting Interoperability score. All practices need to report data with a minimum numerator score of 1 (i.e., one patient that meets the measure requirement) from at least one measure in each of the four objectives to earn a score of greater than zero in the Promoting Interoperability category. In 2019, the Security Risk Analysis is no longer considered a Promoting Interoperability measure, but it must be performed in 2019 or the practice will receive a score of zero points in the Promoting Interoperability category. Practices will need to attest that they are actively engaged with a minimum of two unique registries to earn the 10 points in the Public Health and Clinical Data Registry Reporting objective/measure.

### Table 3: 2019 Promoting Interoperability Objectives, Measures, and Scoring[4]

| **Objective** | **Measure** | **Maximum Points** |
|---|---|---|
| e-Prescribing | e-Prescribing* | 10 |
| | *Bonus:* Query of Prescription Drug Monitoring Program (PDMP) | 5-point bonus |
| | *Bonus:* Verify Opioid Treatment Agreement | 5-point bonus |
| 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 | Report to two different public health agencies or clinical data registries for any of the following:<br>• Immunization Registry Reporting*<br>• Electronic Case Reporting*<br>• Public Health Registry Reporting*<br>• Clinical Data Registry Reporting*<br>• Syndromic Surveillance Reporting* | 10 |

* *Exclusions available*

The total number of potential Promoting Interoperability category points (including the 50 points achieved through base measures) has been reduced from 165 points in 2018 (see Table 2 above) to a maximum of 110 points in 2019 (see Table 3), although in both years the score is capped at 100 points. The removal of the 50-point base measure score and other changes will make it more challenging for practices to achieve high scores in the Promoting Interoperability category in 2019.

Exclusions exist for many of the measures, as shown in Table 3 above. If an exclusion is claimed for the e-prescribing measure, its point value (10 points) is reassigned equally to the two health information exchange measures. If an exclusion is claimed for either health information exchange measure, the associated 20 points would be attributed to the other health information exchange measure. Note, there is no exclusion for the "Provide Patients Electronic Access to Their Health Information" measure, making it important for practices to invest in patient portals or other approved mechanisms for allowing patients to access their records electronically. For the Public Health and Clinical Data Exchange objective, practices will need to claim an exclusion for at least two measures in order for the points in this measure to be reassigned. When this occurs, the points are reassigned to the "Provide Patients Electronic Access to Their Health Information" measure and the two health information exchange measures.

CMS has stated that despite the significant changes to the Promoting Interoperability category for the 2019 performance year, EHRs that are certified based on the 2015 Edition criteria will not be required to undergo recertification. However, EHR and other health IT vendors will need time to reconfigure their dashboards and other tools to accommodate these changes.

In summary, changes to the Promoting Interoperability category in 2019 will require updates to CEHRT and other health IT products. It will also require many practices to improve their Promoting Interoperability category performance in 2019 to achieve scores that are similar to what they received in 2017 and 2018. This may be achieved in part by targeting high performance in this category as early as possible during the calendar year, allowing for several 90-day "practice runs" that may identify areas that require improvement.

## MIPS Cost Performance Category in 2019

As noted previously, the cost performance category of MIPS has a weighting of 15 percent in the 2019 performance year. CMS plans to increase the weighting to 20 percent in the 2020 performance year and then 25 percent in the 2021 performance year. In 2022, the weighting of the MIPS cost category will reach its statutorily required maximum weighting of 30 percent.

CMS will continue to measure performance for the Cost category using the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures in 2019. These measures have retained their case minimums of attributed patients (35 patients for the MSPB measure and 20 patients for the TPCC measure).

CMS authorized the use of eight episode-based cost measures for the 2019 performance period. These measures are based on episode groups, as shown in Table 4 below. Measures from two of the three types of episode groups (procedural, acute inpatient medical condition, and chronic medical condition) have been approved for use in 2019. Measures from the chronic

condition episode group type may be introduced as early as 2020. CMS plans to increase the number of episode-based measures over time and is statutorily required to target implementing cost measures that address over 50 percent of all Part A and Part B Medicare payments.

**Table 4: Episode-based Cost Measures Approved for the 2019 Performance Year**

| Measure Name | Type | Case Minimum |
|---|---|---|
| Elective Outpatient Percutaneous Coronary Intervention (PCI) | Procedural | 10 |
| Knee Arthroplasty | Procedural | 10 |
| Revascularization for Lower Extremity Chronic Critical Limb Ischemia | Procedural | 10 |
| Routine Cataract Removal with Intraocular Lens (IOL) Implantation | Procedural | 10 |
| Screening/Surveillance Colonoscopy | Procedural | 10 |
| Intracranial Hemorrhage or Cerebral Infarction | Acute inpatient medical condition | 20 |
| Simple Pneumonia with Hospitalization | Acute inpatient medical condition | 20 |
| ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) | Acute inpatient medical condition | 20 |

The case minimums are 20 attributed cases for the acute inpatient episode-based measures and 10 attributed cases for the procedural measures. The case minimums are the same for clinicians that report as individuals and for those that report as a group, regardless of size.

CMS will attribute cost associated with each measure to individual clinicians or groups, depending on the chosen reporting method. For the MSPB measure, episodes (i.e., hospitalizations) are attributed to the single TIN-NPI that billed the plurality of Medicare Part B claims during the hospital stay and are further weighted towards the clinician that provided the most services with an inpatient place of service (POS) code or the clinician that provided the most Part B services on the discharge date.

Attribution for the TPCC measure is based on the single TIN-NPI (i.e., clinician) that provided the most primary care services and the primary care clinician specialty types that provided the most services to a given Medicare beneficiary. If a beneficiary received more primary care services from a specialist physician than from a primary care clinician, the beneficiary is attributed to the specialist. Primary care services are identified by HCPCS codes and primarily made up of E&M codes.

For the episode-based measures, the attribution methodology varies by episode group type (procedural or acute inpatient medical condition). For the procedural measures the episode is attributed to the clinician that renders the trigger service (i.e., a specific procedure assigned to that measure based on HCPCS codes). For the acute inpatient medical condition measures, the trigger event is a specified Medicare Severity-Diagnosis Related Group (MS-DRG). The episode is attributed to each MIPS-eligible clinician who bills inpatient E&M claim lines during a hospitalization if the clinician or the clinician's group bills for at least 30 percent of the inpatient E&M claim lines during that hospitalization.

Episode-based measures exclude costs not related to the trigger event. This is in contrast to the MSPB measure, where all costs—regardless of billing provider—during the episode window for the MSPB measure (i.e., three days prior to the admission through 30 days post-discharge) are used to determine the cost for each episode. Care costs during the episode window not related to the reason for admission that triggered the MSPB episode are excluded.

If the practice is scored on more than one measure, the average performance score versus national benchmarks across the applicable measures is used to determine the final cost score for the practice. If the case minimum requirements cannot be met for any of the 10 cost measures (i.e., the MSPB, TPCC, and eight episode-based measures), then the cost category is given a weighting of zero percent. The cost category's previously assigned weighting of 15 percent is then reallocated to the MIPS quality performance category, which would give quality a weighting of 60 percent.

CMS will use standardized national Part A and Part B claims data to determine median cost points for the TPCC, MSPB, and the eight episode-based measures that will serve as benchmarks. Expenditures attributed to the practice are then compared to the benchmark and this determines the performance score for the practice for a given measure. These benchmarks are created each year and applied against cost performance in the same calendar year. For example, the benchmark for the TPCC measure in 2019 will not be calculated until 2020, but it will be used to determine TPCC measure performance for the 2019 performance year.

Medicare uses a process called payment standardization that allows costs to be compared nationally. For example, allowed claims amounts may be affected by regional or program-specific payment adjustments. Fee schedules are adjusted for regional difference in wage levels for different geographic locations. Provider organizations may also have had payments adjusted based on quality-based performance, payment for medical education, payment adjustments for rural health, etc. Standardization removes costs not related to healthcare delivery choices. In other words, CMS attempts to normalize cost data so that cost performance can be fairly compared across disparate settings of care (i.e., rural Nebraska vs. New York City).

CMS defines cost for episode groups as "…allowed amounts on Medicare claims, which include both Medicare payments and beneficiary deductible and coinsurance amounts."[5] Cost determination is limited to Part A- and Part B-allowed charges that represent a clinically cohesive set of medical services for treatment of a given medical condition or procedure. Episode groups have defined time periods referred to as "windows." For example, the Revascularization for Lower Extremity Chronic Critical Limb Ischemia measure has a 30-day pre-trigger period and a 90-day post-trigger period, with the trigger being date of the surgical procedure. Episode groups may overlap with each other.

Episode-based cost is limited to an aggregate of all items and services provided to a defined patient cohort. This could include treatment, diagnosis, or ancillary services and ancillary items. Cost for an episode is based on the cost of care for a "trigger" condition (i.e., simple pneumonia with hospitalization) or costs associated with a "trigger" procedure (i.e., knee arthroplasty) during a defined time window. Measure specification documents that specify episode triggers, exclusions, episode sub-groups, assigned items and services, and risk adjustors are available on the Quality Payment Program website (https://qpp.cms.gov).

The cost of care for each episode—and for the TPCC and MSPB measures—is risk-adjusted using CMS-HCC coding and for some measures includes risk factors specific to the cost measure. Ensuring that all chronic conditions are properly documented and assigned the most accurate ICD-10-CM code will result in higher cost performance for practices.

CMS will assign a score of between one to 10 points for each measure that meets the case minimum requirement for attributed beneficiaries, based on how it compares to the benchmark for that measure. Practices do not need to report data for this performance category as Medicare will base performance on submitted claims.

## MIPS Quality Performance Category in 2019

CMS is continuing with its "Meaningful Measures" initiative through work with seven awarded cooperative agreement partnerships. CMS is in the process of developing additional outcome-based quality measures that better demonstrate improvements in patient care. CMS elected to create new terms for quality and other category reporting activities (see Figure 3 below).

### Figure 3: New MIPS Terms for 2019

- **Collection Type** is a set of quality measures with comparable specifications and data completeness criteria including, as applicable: electronic clinical quality measures (eCQMs); MIPS clinical quality measures (CQMs) (formerly referred to as "registry measures"); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey measure; and administrative claims measures.
- **Submitter Type** is the MIPS eligible clinician, group, or third-party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities.
- **Submission Type** is the mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. There is no submission type for cost data because the data is collected and calculated by CMS from administrative claims data submitted for payment.

Starting with the 2019 performance year, groups may submit and be scored on quality measures using more than one "collection type." This is significant as the same measure may have two or more collection types with differing benchmarks. For example, if a practice submits quality data on the same quality measure via both the CQM and eCQM collection types, they may receive different scores depending on unique benchmarks tied to the measures collection type. When the same measure is reported using two collection types CMS will choose the highest scoring measure for performance determination.

Small group practices may report via the claims reporting mechanism in 2019. Formerly, this was limited to clinicians reporting as individuals. CMS is also maturing the process whereby quality measures that traditionally have very high performance (i.e., "topped-out" measures) are being removed. CMS added 10 new quality measures and removed a total of 26 topped-out and otherwise "non-clinically useful" measures in 2019.

## MIPS Improvement Activities Performance Category in 2019

There were minimal changes made to the improvement activities category for 2019. Six new improvement activities were added, five were modified, and one was removed. As noted previously, the five percent Promoting Interoperability bonus associated with the use of certain improvement activities has been removed.

## MIPS Reporting Options for Facility-based Clinicians

Clinicians that are facility-based can use their hospital's performance under the Hospital Value-Based Purchasing (VBP) Program for the MIPS quality and cost performance categories. Facility-based clinicians are defined as clinicians that furnish 75 percent or more of their covered professional services in inpatient hospitals, on-campus outpatient hospitals, or emergency rooms. For groups, 75 percent or more of the clinicians in the group need to meet this same individual clinician facility-based requirement.

Facility-based practices retain the option of submitting quality category performance data based on the MIPS quality category performance. If the practice submits MIPS quality data, CMS will use the higher of the two performance scores for the quality and cost categories (i.e., VBP vs. MIPS) as the performance score for the quality and cost categories. The practice will need to attest to meet the requirements for improvement activities. Depending on exclusion status the practice may also need to report Promoting Interoperability performance data.

## MIPS Bonuses in 2019

CMS has discontinued the five percent small practice bonus that is applied to the total MIPS score in 2019. Small practices (15 and fewer clinicians) will instead receive a six-point bonus added to their quality scores. As noted above, CMS also removed bonuses in the Promoting Interoperability category for specified improvement activities that involved the use of certified EHR technology.

Bonuses that CMS retained include the complex patient care bonus (up to five points added to the total MIPS score) and bonuses associated with reporting additional outcome, high priority, and end-to-end electronic quality measures.

## Advanced Alternative Payment Models in 2019

There were relatively few changes to Advanced APM requirements for 2019. A brief overview of selected changes is provided below.

### Qualified Participant (QP) Thresholds in 2019

As per statute the percentage of payments and patient volume thresholds to achieve QP and Partial QP status increased for the 2019 performance year (see Table 5 and Table 6 below). This has been partially offset by the approval of the All-Payer Combination and Other Payer Advanced APMs in 2019. These initiatives will allow clinicians participating in non-QPP Advanced APMs that meet CMS approval to have their payment and volume thresholds summated with QPP Advanced APMs. This will allow larger numbers of clinicians to meet the increased thresholds in 2019 and future years. Other APMs may be Medicaid, Medicare Advantage, and CMS multi-payer models or commercial/private payer Advanced APMs.

### Table 5: Qualifying Participant Payment and Patient Volume Thresholds by Year

| **Minimum Requirements for QP Participation in Advanced APMs (Payments or Patient Volume Attributed to APM)** | | | | | | |
|---|---|---|---|---|---|---|
| Performance Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 and Beyond |
| % Payments from APM | 25% | 25% | 50% | 50% | 75% | 75% |
| % Patient Volume from APM | 20% | 20% | 35% | 35% | 50% | 50% |

### Table 6: Partially Qualifying Participant Payment and Patient Volume Thresholds by Year

| **Minimum Requirements for Partial QP Participation in Advanced APMs (Payments or Patient Volume Attributed to APM)** | | | | | | |
|---|---|---|---|---|---|---|
| Performance Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 and Beyond |
| % Payments from APM | 20% | 20% | 40% | 40% | 50% | 50% |
| % Patient Volume from APM | 10% | 10% | 25% | 25% | 35% | 35% |

A significant number of MIPS-eligible clinicians that met the thresholds for partial QP status in 2017 and 2018 may find themselves not meeting the new threshold requirements in 2019. When this occurs clinicians will receive a MIPS score that is not determined by the MIPS APM scoring standard (i.e., it will be based on their or their group's performance in the four MIPS categories). MIPS-eligible clinicians with historical APM payment percentages in the range of 20 percent and 40 percent and APM patient volumes in the range of 10 percent and 25 percent may wish to consider having a MIPS performance strategy in place for 2019 and future years.

**Certified Electronic Health Records Technology (CEHRT) Usage in 2019**

Advanced APMs must require that at least 75 percent of eligible clinicians in each APM entity are using CEHRT in 2019.

## More Information Available in the Final Rule

This article provides an overview of changes to the Quality Payment Program in 2019. Please see the QPP section of the 2019 Physician Fee Schedule Final Rule and emerging guidance from CMS for additional information. Additional information from this author pertaining to the 2018 QPP performance year is also available, published in an article in the February 2018 issue of *Journal of AHIMA*.[6]

## Notes

1. Centers for Medicare and Medicaid Services. "83 FR 59452 (2019 Medicare Physician Fee Schedule Final Rule)." *Federal Register*. November 23, 2018. www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.
2. Ibid.
3. Ibid.
4. Ibid.
5. Ibid.
6. Marron-Stearns, Michael. "MACRA Strategies for 2018 and 2019 (Update)." *Journal of AHIMA* 89, no. 2 (February 2018): 22-27. http://bok.ahima.org/doc?oid=302408.

## Reference

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