Hot Topics In Reimbursement 2018

Bobbi Buell MBA
800-795-2633
bbuell@onpointoncology.com
Bobbibuell1@yahoo.com
NEWSLETTER: www.onpointoncology.com

Disclaimer

- The information described herein is subject to change as many of the details herein are subject to interpretation.
- CPT codes and descriptions only are copyright 2016 American Medical Association (AMA). All rights reserved. The AMA assumes no liability for data contained or not contained herein.
- All Medicare information is derived from published rules; however, interpretations may be erroneous and typos may be evidenced. It is mandatory that coding and billing is based on information derived from each practice or clinic.
- This is not legal or payment advice.
- This content is abbreviated for Medical Oncology. It does not substitute for a thorough review of code books, regulations, and Carrier guidance.
- This information is valid for the date of presentation only.
- This presentation should not be reproduced without the permission of the author and is time sensitive

AGENDA

- Final Physician Fee Schedule 2018
- Hospital Outpatient Final Rule 2018
- MIPS/QPP 2018
- Oncology Coding 2018

Final Physician Fee Schedule and Hospital Outpatient Prospective Payment 2018

Web Sites for 2018 FINAL Regulations

- This presentation is based on published rules
  - PHYSICIANS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/
  - HOPPS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html

Medicare Physician Payment Basics

- Payments are based on RVUs for each code (WRVUs+PERVUs+MalRVUs)
- RVUs are multiplied times GPCIs for your geographical location (W*WGPCI+PE*PEGPCI+Mal*MalGPCI)
- The Medicare conversion factor determines the overall level of Medicare payments (W*WGPCI+PE*PEGPCI+Mal*MalGPCI) times CF = $Your Total Allowable for your area

CONVERSION FACTOR 2018

TABLE 48: Calculation of the Final CY 2018 PFS Conversion Factor

CY 2017 Conversion Factor		**35.8887**
Statutory Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)	
CY 2018 Conversion Factor		**35.9996**

Source: PHYSICIAN Fee Schedule Final Rule 2018

Fee Schedule: Does Not Include Sequestration

- Sequestration:
  - Medicare 2% across the board started on April 1, 2013
  - Impacts everything including drugs
  - The 2% comes out of the Medicare portion (80%)
    - Drugs are paid at 104.304% ASP
    - All patient payments excluded
- Murray-Ryan Budget Deal extended the Sequester until 2023; PAMA extended it to 2024, and the latest budget deal extends it to 2025
- The most recent Republican tax plan includes an additional 2% of sequestration. It is not yet finalized.

Impact On Hem-Onc: Final Rule 2018

TABLE 50: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$93,149	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$247	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,018	-1%	0%	0%	-1%
AUDIOLOGIST	$66	0%	0%	0%	0%
CARDIAC SURGERY	$312	0%	0%	0%	0%
CARDIOLOGY	$6,705	0%	-1%	0%	1%
CHIROPRACTOR	$779	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$762	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$670	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$167	0%	0%	0%	0%
CRITICAL CARE	$334	0%	0%	0%	0%
DERMATOLOGY	$3,485	0%	1%	0%	1%
DIAGNOSTIC TESTING FACILITY	$773	0%	-4%	0%	-4%
EMERGENCY MEDICINE	$3,191	0%	0%	0%	0%
ENDOCRINOLOGY	$480	0%	0%	0%	0%
FAMILY PRACTICE	$6,350	0%	0%	0%	0%
GASTROENTEROLOGY	$1,801	0%	0%	0%	0%
GENERAL PRACTICE	$458	0%	0%	0%	0%
GENERAL SURGERY	$2,170	0%	0%	0%	0%
GERIATRICS	$212	0%	0%	0%	0%
HAND SURGERY	$201	0%	0%	0%	0%
HEMATOLOGY/ONCOLOGY	$1,809	0%	0%	0%	0%
INDEPENDENT LABORATORY	$690	0%	-1%	0%	-1%
INFECTIOUS DISEASE	$656	0%	0%	0%	1%
INTERNAL MEDICINE	[illegible]	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	[illegible]	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$360	0%	0%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHYS	$140	[illegible]	0%	0%	0%
NEPHROLOGY	$2,270	0%	0%	0%	0%

Revalued Codes

- This is an annual exercise for codes registering over $10 million in expenditures. If enough cannot be derived from this process, it will be taken out of the conversion factor.
- CMS re-evaluated these codes with little impact to their RVUs:
  - 96401
  - 96402
  - 96409
  - 96411

INR Monitoring 2018

- There is a new CPT code for INR Management. It is 93793 for
  - Monitoring of patient on warfarin
  - Evaluation of results
  - Patient instructions
  - Dose adjustment
  - Scheduling
  - Office visits are bundled
- There is also a code for INR teaching for patients and caregivers, 93792.

Other Coding Changes Proposed for 2018

- Superficial Radiation Treatment (”GRRR1”), which includes:
  - CPT code 77261 (Therapeutic radiology treatment planning; simple),
  - CPT code 77280 (Therapeutic radiology simulation-aided field setting; simple),
  - CPT code 77300 (Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician),
  - CPT code 77306 (Teletherapyisodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)),
  - CPT code 77332 (Treatment devices, design and construction; simple (simple block, simple bolus)), and
  - CPT code 77427 (Radiation treatment management, 5 treatments).
- Based on comments, this was not finalized in the Final Rule.

More Coding Changes for 2018

- CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for chronic care management and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-codes..
  - Will be reviewed in our CPT Section
- 96377 will have RVUs and they will be 0.57 RVUs, if the proposal is finalized

Telehealth Services—Additions for 2018

- For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:
- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis)
- Modifier –GT will no longer be necessary

Changes to Digital Imaging

- Section 1848(b)(9)(B) of the Act provides for a 7 percent reduction in payments for the technical component (TC) for imaging services made under the PFS that are X-rays (including the technical component portion of a global service) taken using computed radiography technology furnished during CYs 2018, 2019, 2020, 2021, or 2022, and for a 10 percent reduction for the technical component of such imaging services furnished during CY 2023 or a subsequent year.
- X-rays taken using computed radiography technology during CY 2018 or subsequent years, CMS is proposing to establish a new modifier to be used on claims for these services.

Part B Drug Changes 2018

The 21st Century Cures Act changed the payment for drugs given through ***Durable Medical Equipment***. It as formerly 95% of AWP, but as of January 1, 2017, it went to ASP plus 6% as mandated by law.

Biosimilars

- CMS will publish new J-codes for Biosimilars. As recommended by the AMA, CMS reversed previous proposed policy on coding and payment for biosimilars and will now provide for separate coding and payment for each approved biosimilar product.
- Previous policy would have grouped all biosimilars for a single originator product into a single HCPCS code and payment amount.
- CMS noted that most commenters believed that the previous proposed policy of including all grouping biosimilars into the same code/payment would decrease incentives for biosimilar development and limit provider choices.

Evaluation & Management Services: Request for Comments

Since the early 1990s, three components have dominated Evaluation & Management coding in terms of levels of service:

- History
- Physical
- Medical Decision-making

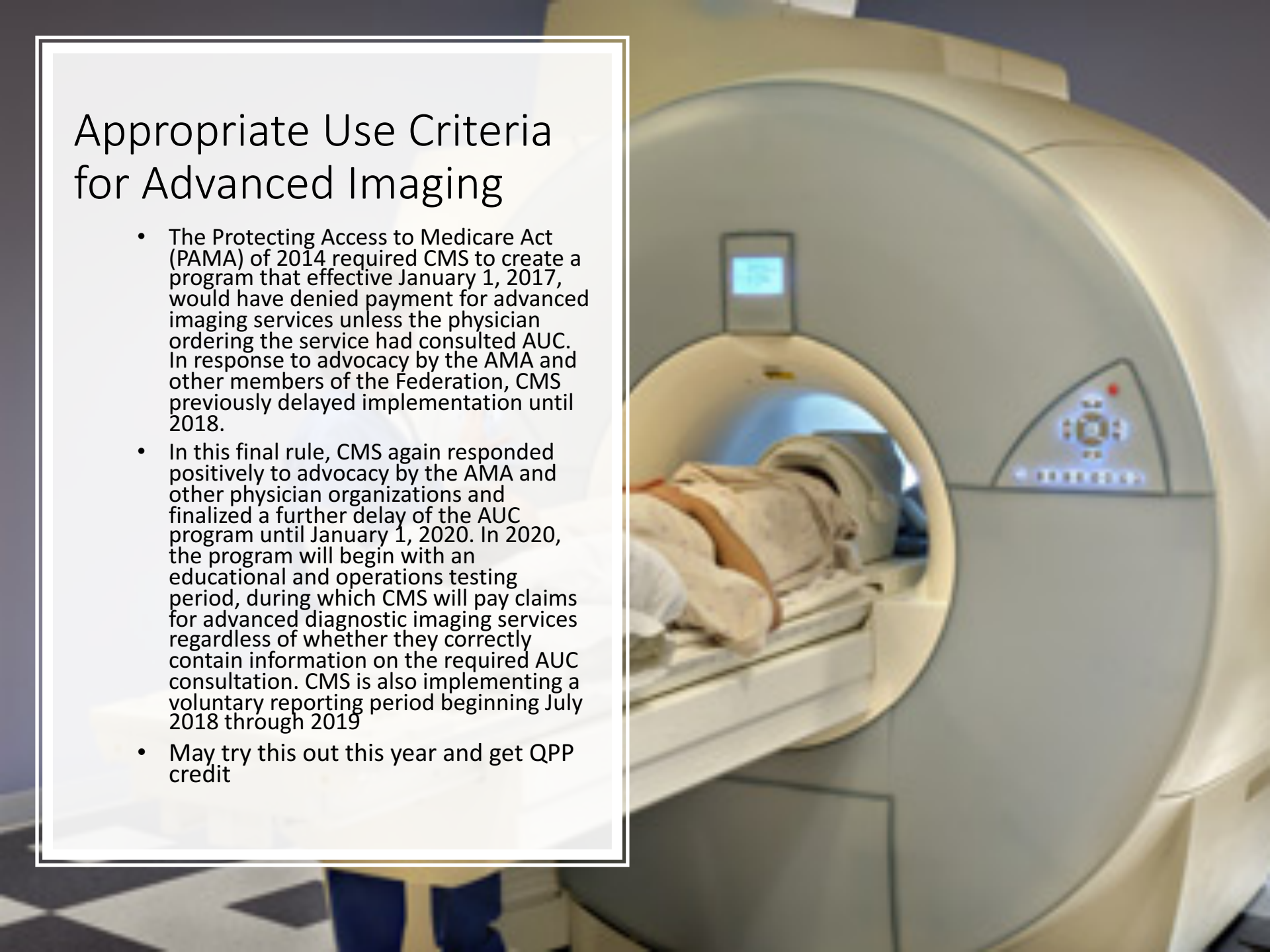
In the 2018 proposed rule, CMS asked for comments on revisions to the E/M documentation guidelines that would reduce administrative burden to physicians. CMS relayed that commenters did not agree on how the current standards should be changed, and different specialties expressed different challenges and recommendations regarding the guidelines. However, the agency also noted that it continues to believe revised documentation guidelines could reduce clinical burden, and it is considering the best approach for collaboration to develop and implement potential changes going forward.

PAMA Reporting and the Clinical Laboratory Fee Schedule

- Under the PAMA Law, all clinical lab tests will be paid starting January 1, 2018, based on the median of private payer rates as derived from January 1-June 30, 2016. This was reported January-May of 2017.
  - This reporting will happen every 3 years
  - CMS wants comments on data collection and reporting.

Appropriate Use Criteria for Advanced Imaging

- The Protecting Access to Medicare Act (PAMA) of 2014 required CMS to create a program that effective January 1, 2017, would have denied payment for advanced imaging services unless the physician ordering the service had consulted AUC. In response to advocacy by the AMA and other members of the Federation, CMS previously delayed implementation until 2018.
- In this final rule, CMS again responded positively to advocacy by the AMA and other physician organizations and finalized a further delay of the AUC program until January 1, 2020. In 2020, the program will begin with an educational and operations testing period, during which CMS will pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. CMS is also implementing a voluntary reporting period beginning July 2018 through 2019
- May try this out this year and get QPP credit



Patient Relationship Coding

- These are voluntary in 2018, but may become mandatory later:

1. Continuous/broad (X1): This category could include clinicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role. Examples include, but are not limited to: Primary care, specialists providing comprehensive care to patients in addition to specialty care, etc.
2. Continuous/focused (X2): This category could include a specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. Examples include, but are not limited to: A rheumatologist taking care of a patient's rheumatoid arthritis longitudinally but not providing general primary care services.
3. Episodic/broad (X3): This category could include clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization. Examples include, but are not limited to: A hospitalist providing comprehensive and general care to a patient while admitted to the hospital.
4. Episodic/focused (X4): This category could include a specialist focused on particular types of time-limited treatment. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention. Examples include, but are not limited to: An orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.
5. Only as ordered by another clinician (X5): This category could include a clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians. Examples include, but are not limited to: A radiologist interpreting an imaging study ordered by another clinician.

Diabetes Prevention Program 2018

- Coverage of the MDPP services will be available for beneficiaries who meet the following criteria:
  - Enrolled in Medicare Part B;
  - Have, as of the date of attendance at the first core session, a body mass index (BMI) of at least 25 if not self-identified as Asian or a BMI of at least 23 if self-identified as Asian;
  - Have, within the 12 months prior to attending the first core session, a hemoglobin A1c test with a value between 5.7 and 6.4 percent, a fasting plasma glucose of 110-125 mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test);
  - Have no previous diagnosis of type 1 or type 2 diabetes with the exception of gestational diabetes; and
  - Do not have end-stage renal disease (ESRD)

Medicare Diabetes Prevention Programs

- CMS has already solicited provider applications for the program
- The Proposed Rule outlines:
  - Session requirements
  - Start date of April 1, 2018
  - Time frame for services
  - Payments and incentive payments for services
  - Coding and billing

Revisions to PQRS: 2018 Adjustments

- Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures for the CY 2016 reporting period are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS covered professional services. 2016 was the last reporting period for PQRS. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. PQRS is being replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The first MIPS performance period is January through December 2017.
- CMS proposed and is finalizing a change to the current PQRS program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS with no domain requirement.
- They are also finalizing similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals who reported electronically through the PQRS portal

Revisions to Value Modifier: 2018 Adjustments

- CMS finalized several changes to better align the VM program with the MIPS program including:
  - Holding all groups and solo practitioners who met 2016 PQRS reporting requirements harmless from any negative VM payment adjustments in 2018.
  - Halving penalties for those who did not meet PQRS requirements to -2 percent for groups with 10 or more eligible professionals, and to -1 percent for smaller groups and solo practitioners.
  - Reducing the maximum upward payment adjustment to 2 times an adjustment factor that is set at the rate needed to keep penalties and bonuses budget neutral.
  - Dropping its earlier proposal to publicly report 2016 value modifier data on its Physician Compare web site.

More References

- Additional information about the proposed 2018 MPFS can be found at the following links:
- The final rule is available online at:
  - https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-programs- revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions
- Other supporting documents and tables referenced in this final rule are available through the Internet on the CMS website at:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html
- The CMS Press Release and the CMS Fact Sheet on the final rule are available at:
  - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet- items/2017-11-02.html

FINAL HOSPITAL OUTPATIENT RULE 2018

Drug Payment for 340B Entities

- The rule also would drastically cut Medicare payment for drugs that are acquired under the 340B Drug Pricing Program. Specifically, CMS will pay separately payable, non pass-through drugs (other than vaccines) purchased through the 340B program at the average sales price minus 22.5%, rather than ASP plus 6%
- Beginning January 1, 2018, DHHS will be requiring a modifier to identify whether a drug billed under the OPPS was purchased under the 340B Drug Discount Program.
  - All drugs purchased by DSH and rural referral centers through the 340B Drug Discount Program will have to be billed to Medicare with a "JG" (drug or biological acquired with 340B drug pricing program discount) modifier. The requirement to use the JG modifier applies only to OPPS separately payable drugs (status indicator K) and does not apply to vaccines (status indicator L or M) or drugs with transitional pass-through payment status (status indicator G)
  - Rural sole community hospitals, children's hospitals, and PPS–exempt cancer hospitals will be required to report an informational modifier "TB" (drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) for tracking and monitoring purposes to identify OPPS separately payable drugs purchased with a 340B discount

http://www.340bhealth.org/files/340B_Health_Analysis_of_HOPPS_Final_Rule_11.7.17.pdf

Drug Payment for 340B Entities

- Pass-through Drugs are exempt from the reduction. A list of the 50 drugs and biologicals with pass-through status for CY 2018 or have been granted pass-through payment status as of January 2018 can be found in Table 70 on page 491 of the Final Rule.
- The payment reduction will generally not apply to retail drugs, including those dispensed by 340B contract pharmacies, as they are not paid under the OPPS

http://www.340bhealth.org/files/340B_Health_Analysis_of_HOPPS_Final_Rule_11.7.17.pdf

2018 Drug Payments

Drugs, unless they are purchased under 340B discounting, will be paid at Average Sales Price plus 6%

All drugs whose cost is $120 or less per encounter, according to CMS, will be bundled into the APC. This a $10 increase from last year as usual

Radiopharmaceuticals will also have a $120 packaging threshold

Bundling of Drug Administration Services for 2018

Medicare will bundle 'low cost' drug administration services in 2018, unless they are the only service

They are also soliciting comments on bundling add-on drug administration codes

HOPPS Bundling Finalized 2018

TABLE 8—CY 2018 STATUS INDICATORS FOR DRUG ADMINISTRATION SERVICES IN LEVEL 1 AND LEVEL 2 DRUG ADMINISTRATION APCS

HCPCS code	Short descriptor	CY 2018 status indicator
APC 5691—Level 1 Drug Administration		
95115	Immunotherapy one injection	Q1
95117	Immunotherapy injections	Q1
95144	Antigen therapy services	Q1
95145	Antigen therapy services	Q1
95146	Antigen therapy services	Q1
95165	Antigen therapy services	Q1
95170	Antigen therapy services	Q1
96361	Hydrate iv infusion add-on	S
96366	Ther/proph/diag iv inf addon	S
96370	Sc ther infusion addl hr	S
96375	Tx/pro/dx inj new drug addon	S
96377	Application on-body injector	Q1
96379	Ther/prop/diag inj/inf proc	Q1
96423	Chemo ia infuse each addl hr	S
96549	Chemotherapy unspecified	Q1
G0008	Admin influenza virus vac	S
G0009	Admin pneumococcal vaccine	S
G0010	Admin hepatitis b vaccine	S
APC 5692—Level 2 Drug Administration		
90471	Immunization admin	Q1
90473	Immune admin oral/nasal	Q1
95147	Antigen therapy services	Q1
95148	Antigen therapy services	Q1
95149	Antigen therapy services	Q1
96367	Tx/proph/dg addl seq iv inf	S

Q1 = Bundled with Other Services; Payable Alone

HOPPS Bundling Finalized 2018

TABLE 8—CY 2018 STATUS INDICATORS FOR DRUG ADMINISTRATION SERVICES IN LEVEL 1 AND LEVEL 2 DRUG ADMINISTRATION APCS—Continued

HCPCS code	Short descriptor	CY 2018 status indicator
96371	Sc ther infusion reset pump	Q1
96372	Ther/proph/diag inj sc/im	Q1
96401	Chemo anti-neopl sq/im	Q1
96402	Chemo hormon antineopl sq/im	Q1
96405	Chemo intralesional up to 7	Q1
96411	Chemo iv push addl drug	S
96415	Chemo iv infusion addl hr	S
96417	Chemo iv infus each addl seq	S

Q1 = Bundled with Other Services; Payable Alone

Section 603: Site Neutral Policy

- In the Fee Schedule Rule, CMS implements Section 603 of the Bipartisan Budget Act of 2015, which requires that:
  - With the exception of Emergency Department ("ED") items and services,
  - All "NEW" off-campus provider-based departments ("PBDs"), meaning those that started billing under OPPS on/after November 2, 2015 would:
    - No longer be covered hospital outpatient services
    - Be paid under other Part B 'applicable payment system'
    - Started January 1, 2017

Section 603: Payment for 2018

Proposal: Would be reduced by 50% meaning that for PBDs in 2018, entities would be paid 25% of the HOPPS fee schedule

- INSTEAD, these entities will be paid at 40% of the HOPPS rate
- This does not include drugs or labs
- No 340B reduction for these entities

Payment Update for APCs

- For CY 2018, CMS is increasing the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 1.35 percent. This increase factor is based on
  - the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS),
  - minus the multifactor productivity (MFP) adjustment of 0.6 percentage point, and minus a 0.75 percentage point adjustment required by the Affordable Care Act.
  - Based on this update, we estimate that total payments to OPPS providers (including beneficiary cost- sharing and estimated changes in enrollment, utilization, and case-mix) for CY 2018 is approximately $70 billion, an increase of approximately $5.8 billion compared to estimated CY 2017 OPPS payments
- This does not factor in the 340B changes

Laboratory: Revisions to the 14-day Rule

Currently, if a test is performed on a specimen 14 days or less from the time the specimen was removed, the date of the test is the date of COLLECTION and the hospital must bill for the test.

Will allow the date of the test, not the date of collection, but only if specimens are collected during an outpatient procedure.

Drug Administration—U.S. Averages (Final) 2018

Code	Descriptor	2017 PFS	2018 PFS	2017 APC	2018 APC
96361	Sequential hydration	$15.43	$14.04	$34.89	$37.03
96367	Sequential therapeutic infusion	$31.22	$32.04	$52.69	$58.20
96372	Therapeutic injection	$25.84	$20.88	$52.69	$58.20 (Q1)
96413	Chemotherapy infusion, initial	$139.61	$144.72	$280.41	$297.54
96417	Chemotherapy infusion, sequential	$66.03	$69.48	$52.69	$58.20

Bobbi Buell

November, 2017

THE QPP & MIPS 2017 & Final Rule for 2018

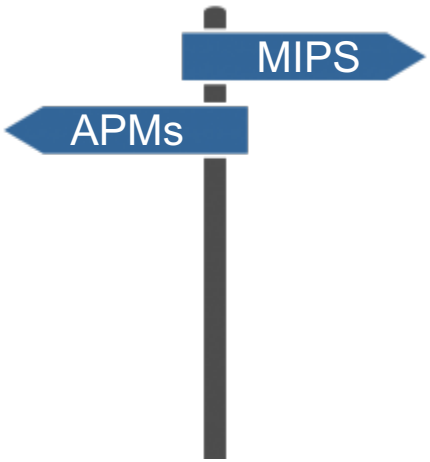
Creation and Demolition of the SGR

- The sustainable growth rate (SGR) was created by the *Balanced Budget Act of 1997* as a means to control Medicare spending by tying Medicare clinician payments to increases in the gross domestic product (GDP).
- When health spending outpaced GDP, negative payment updates were threatened as a result.
- Due to the inability to find sufficient offsets, the SGR was unable to be repealed for nearly two decades.

Congress passed 17 patches to avoid cuts (implementing cuts twice)

MACRA established two Medicare paths for physicians

- MACRA offers physicians a choice between two payment pathways:
  - A modified fee-for-service model (MIPS)
  - New payment models that reduce costs of care and/or support high-value services not typically covered under the Medicare fee schedule (APMs)
- In the beginning, most are expected to participate in MIPS as APMs may or may not apply to everyone
- CMS named the physician payment system created by the Medicare Access and CHIP Reauthorization Act (MACRA) law the Quality Payment Program (QPP)



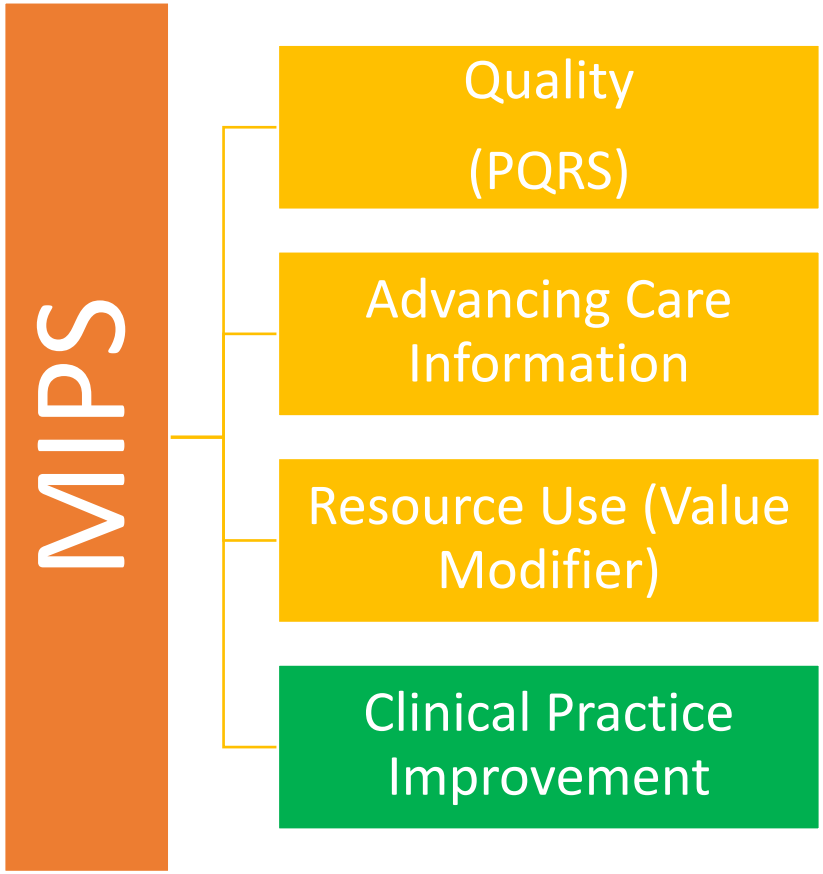
Current Advanced APMs

Comprehensive ESRD Care Model (13 ESCOs)	Comprehensive Primary Care Plus (14 states, practice applications closed 9/15/16)	Medicare Shared Savings Track 2 (6 ACOs, 1% of total)
Medicare Shared Savings Track 3 (16 ACOs, 4% of total)	Next Generation ACO Model (currently 18)	Oncology Care Model Track 2 (A portion of 196 practices will qualify)

Advanced APMs for 2018

- In 2018, CMS anticipates that clinicians may also earn the incentive payment through sufficient participation in the following new and existing models:
  - Medicare ACO Track 1+ Model
  - New voluntary bundled payment model (Some of these have been discontinued)
  - Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)

Merit-Based Incentive Payment System



- Individual programs continue through 2018
  - 2016 performance year
- MIPS payment begins in 2019 for physicians and most mid-level clinicians
  - 2017 performance year
- Eligible professionals scored against benchmark based on prior year's performance
- Low-volume providers and some APM participants can be exempt from MIPS requirements
- In 2018 reporting, some differences for small practices

Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that

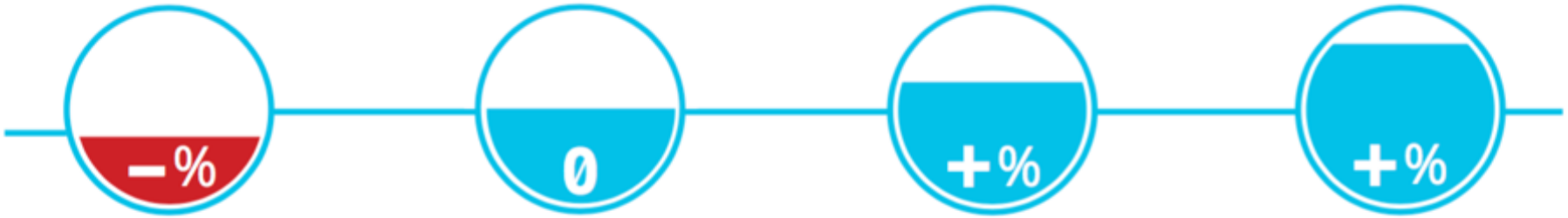
Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

Flow of Events: 2017

How Can You Participate in 2017?



Don't Participate

Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Submit a Partial Year

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Submit a Full Year

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

MIPS Adjustment/Bonuses

- Based on composite performance score EPs may receive an upward, downward or no payment adjustment

Year	Penalty Cap	Value-based Bonus (Up to)
2019	-4.0%	+12%
2020	-5.0%	+15%
2021	-7.0%	+21%
2022	-9.0%	+27%

- Exceptional Performers see significant opportunities for additional bonuses/adjustments on top of traditional MIPS incentives
  - Available in 2019 through 2024

Category 2017—YEAR 1—FINAL RULE October 14, 2016	QPP %
QUALITY: Most participants: Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days. Groups using the web interface: Report 15 quality measures for a full year. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for MIPS quality. The Oncology Measures Group is gone!	60%
IMPROVEMENT ACTIVITIES: Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days. Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days. Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM	15%
ADVANCING CARE INFORMATION: Fulfill the required measures for a minimum of 90 days: 🌍 Security Risk Analysis 🌍 e-Prescribing 🌍 Provide Patient Access 🌍 Send Summary of Care 🌍 Request/Accept Summary of Care Choose to submit up to 9 measures for a minimum of 90 days for additional credit. OR You may not need to submit Advancing Care Information if these measures do not apply to you.	25%

Way to Select Measures (qpp.cms.gov)

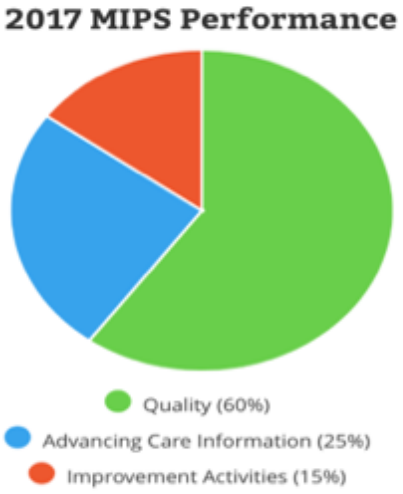
Quality Measures

Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.



Select Measures

Search Filtered by Keyword: Filtered | Search for... | SEARCH

Filter By: High Priority Measure | Data Submission Method | Specialty Measure Set

Clear All Filters | General Oncology ✖

Showing **19** Measures

Q17: How will you be participating in the Medicare's Quality Payment Programs in 2017? (Answer the one that closest resembles what you will be doing, plus any other programs you are in)

- Answered: 160 participants

Answer Choices	Responses	
The Oncology Care Model (one-sided risk)	**29.38%**	47
The Oncology Care Model (two-sided risk)	**5.00%**	8
Accountable Care Organization ("ACO")	**9.38%**	15
MIPS via claims	**15.00%**	24
MIPS via EHR interface	**21.25%**	34
MIPS via EHR download	**8.75%**	14
MIPS via GPRO interface	**0.63%**	1
MIPS via Registry	**30.00%**	48
Qualified Patient -Centered Medical Home	**1.88%**	3
Other (please specify)	**9.38%**	15
Total Respondents: 160		

Final for 2018

Slides from CMS Presentation 7/5/2017

Changes to QPP/MIPS

Page 37 of the Proposed Rule

- *"To further clarify, there are circumstances that involve Part B prescription drugs and durable medical equipment where the supplier may also be a MIPS eligible clinician. In circumstances in which a MIPS eligible clinician furnishes a Part B covered item or service such as prescribing Part B drugs that are dispensed, administered, and billed by a supplier that is a MIPS eligible clinician, or ordering durable medical equipment that is administered and billed by a supplier that is a MIPS eligible clinician, it is not operationally feasible for us at this time to associate those billed allowable charges with a MIPS eligible clinician at an NPI level in order to include them for purposes of applying the MIPS payment adjustment or making eligibility determinations. For Part B items and services furnished by a MIPS eligible clinician such as purchasing and administering Part B drugs that are billed by the MIPS eligible clinician, such items and services may be subject to MIPS adjustment based on the MIPS eligible clinician's performance during the applicable performance period or included for eligibility determinations. For those billed Medicare Part B allowable charges relating to the purchasing and administration of Part B drugs that we are able to associate with a MIPS eligible clinician at an NPI level, such items and services furnished by the MIPS eligible clinician would be included for purposes of applying the MIPS payment adjustment or making eligibility determinations"*

Drugs: Final Rule

- Drugs will be included in your incentive or penalty in 2020 payment
- It is also included in your 10% cost calculation
- PLEASE keep this in mind next year for MIPS reporting and in attributing patients to your practice where costs are concerned.

MIPS Year 2 (2018)

Who is Included?

***Change** to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

Low Volume Threshold Changes

- No change in the types of clinicians eligible to participate in 2018.
- Other types may be added for the 2019 MIPS performance period.
- The same exclusions will remain in the 2018 MIPS performance period:
  - Eligible clinicians new to Medicare.
  - Clinicians below the low-volume threshold.
  - Clinicians significantly participating in Advanced APMs.

Quick Tip:

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

MIPS eligible clinicians include:

No Change: Clinicians Eligible for the QPP

Who Is Exempt Exactly???

MIPS Year 2 (2018)

Who is Exempt?

No Change in Basic Exemption Criteria*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-volume Threshold*

- Non patient-facing:
  - Individuals ≤100 patient facing encounters.
  - Groups: >75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing.
  - Virtual Groups: >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing.

- To reduce burden, non-patient facing MIPS eligible clinicians, groups, and virtual groups would have reduced requirements for two performance categories in the 2018 MIPS performance period.

For **improvement activities**, non-patient facing MIPS eligible clinicians, groups, and virtual groups can report fewer activities (2 medium or 1 high activity) and achieve a maximum improvement activities performance score.

For **advancing care information**, non-patient facing MIPS eligible clinicians, groups, and virtual groups qualify for the reweighting policy, which sets the performance category weight to zero and reallocates the points to other performance categories.

Non-Patient Facing Providers

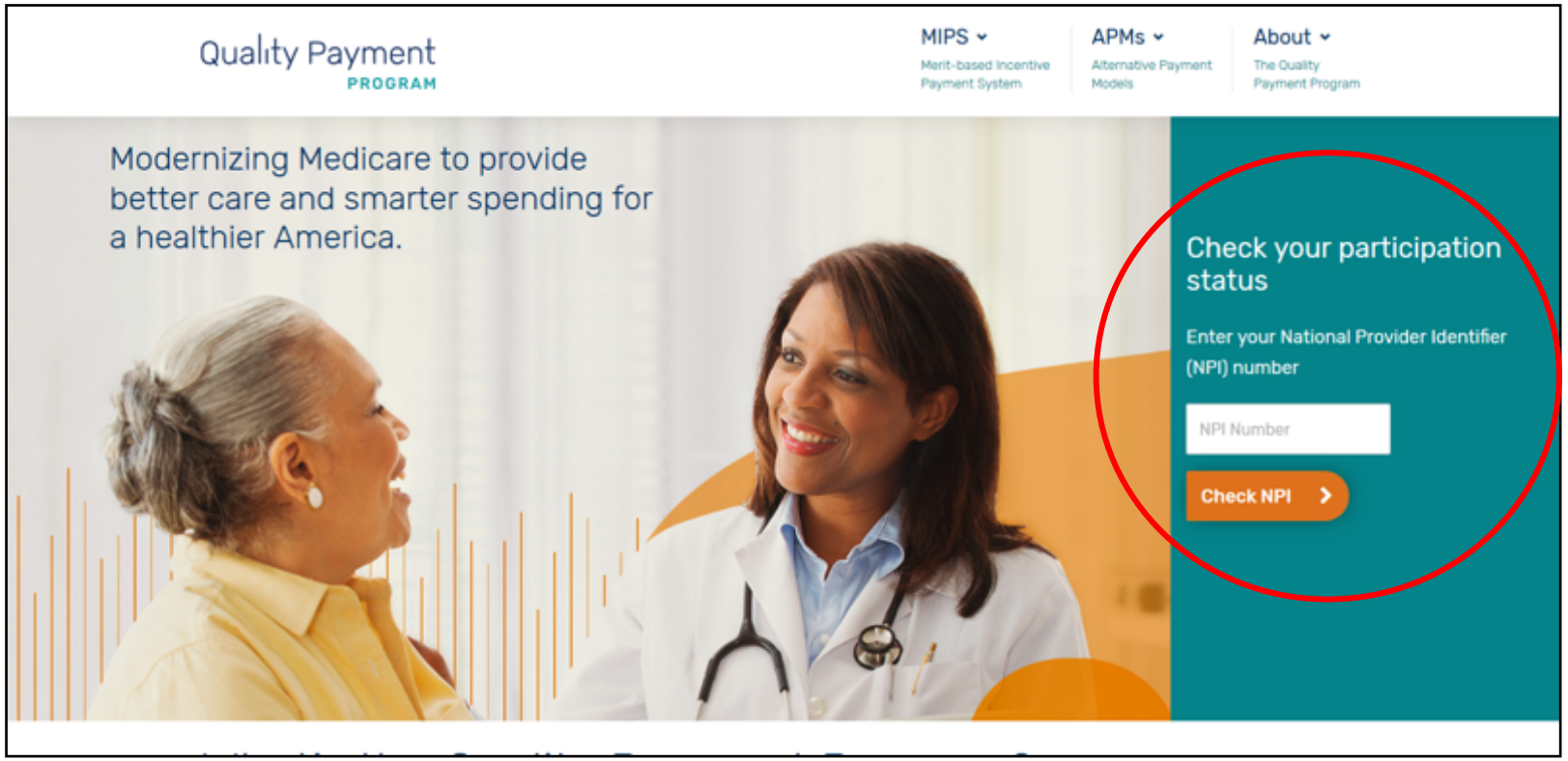
Other Special Statuses

MIPS Year 2 (2018)

Other Special Statuses

Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	• Practices consisting of 15 or fewer eligible clinicians.	• **No change** to the application of these special statuses from Year 1 to Year 2.
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with **more than 75 percent** of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.	

www.qpp.cms.gov



MIPS Year 2 (2018)

Performance Period

Change: *Increase to Performance Period*

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

2018 Performance Period

MIPS Timeline

MIPS Year 2 (2018)

Timeline for Year 2

2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Overall Performance Threshold

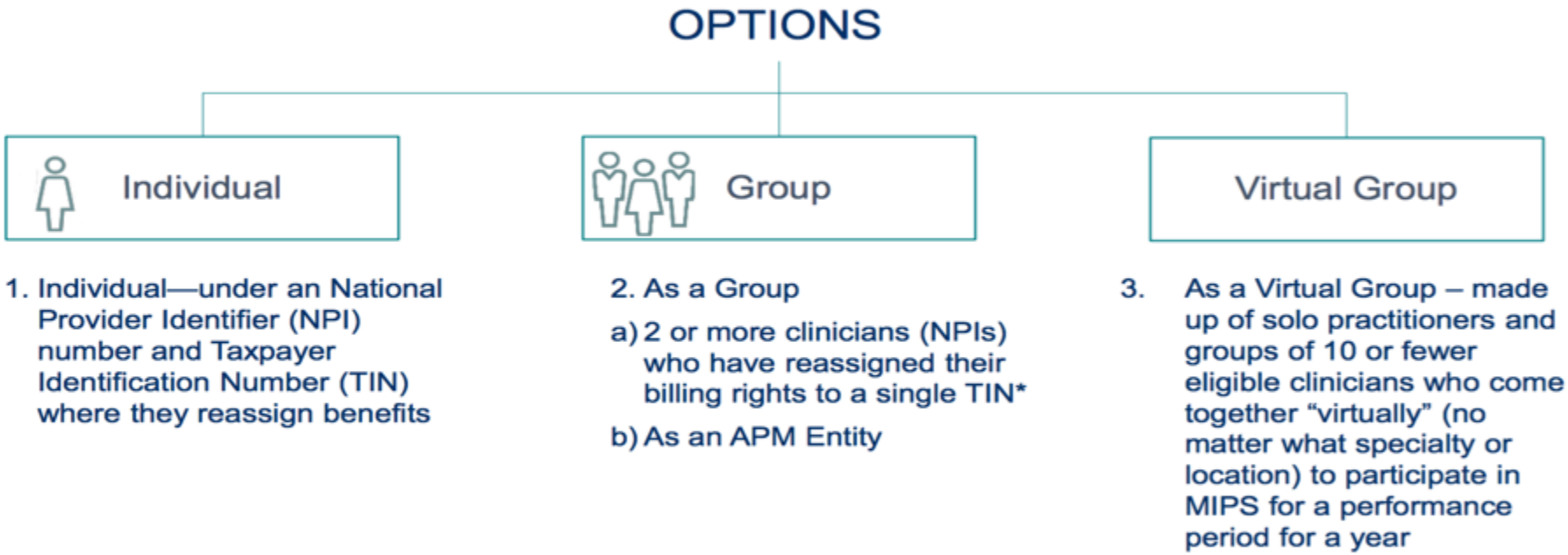
Final Score (Transition Year)	Transition Year Payment Adjustment	Final Score (Year 2)	Year 2 Proposed Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%	≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus	16-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment	15 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not	0 points	• Negative payment adjustment of -5% • 0 points = does not participate

MIPS Scoring Thresholds

Ways To Submit for 2018

MIPS Year 2 (2018)

Reporting Options



* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

Virtual Groups: What???

New: Virtual Groups

What else do I need to know?

- Solo practitioners and groups who want to form a virtual group must go through the **election process**.
- Virtual groups election must occur ***prior*** to the **beginning of the performance period** and cannot be changed once the performance period starts.
- Election period is October 11 to December 31, 2017, for the 2018 MIPS performance period.

Virtual Group Election 2018

New: Virtual Groups

How do I make an election?

- Two-stage election process for virtual groups:
  - **Stage 1 (optional):** Solo practitioners or groups with 10 or fewer eligible clinicians can choose to contact their local Quality Payment Program Technical Assistance organization to see if they are eligible to join or form a virtual group. For contact information on your local Technical Assistance organization, please visit qpp.cms.gov.
  - **Stage 2:** For groups that don't participate in stage 1 of the election process and don't ask for an eligibility determination, CMS will see if they're eligible to be in a virtual group during stage 2 of the election process.

Virtual Group Election

New: Virtual Groups

How do I make an election?

- Each virtual group has to:
  1. Have a **written formal agreement** between each of the virtual group members before election.
  2. Name **an official representative** who e-mails the group's election to MIPS_VirtualGroups@cms.hhs.gov
  3. Each virtual group's official representative must e-mail the group's election by **December 31, 2017.**
  4. Virtual group elections have to include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative's contact information. The virtual group representative would need to acknowledge that a written formal agreement has been established between each member of the virtual group prior to election.
- To learn more, see the 2018 Virtual Groups Toolkit.

Submission: NO Change 2018

MIPS Year 2 (2018)

Submission Mechanisms

No change: *All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Please note:

- Continue with the use of **1** submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The **use of multiple submission mechanisms** per performance category is deferred to Year 3 (2019).

Basics:

- ***Change*: 50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- You may also select a specialty-specific set of measures

Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	• 60%	• 50%
Data Completeness	• 50% for submission mechanisms except for Web Interface and CAHPS. • Measures that do not meet the data completeness criteria earn 3 points.	• 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that do not meet data completeness criteria earn 1 point. • Burden Reduction Aim: Small practices will continue to receive 3 points.

Quality Component (50%) 2018 Reporting

What is the significance?

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

Topped Out Measures:

- Topped-out measures will be removed and scored on 4 year phasing out timeline.
- Topped out measures with measure benchmarks that have been topped out for *at least 2 consecutive years* will receive up to 7 points.
- The 7-point scoring policy for the 6 topped out measures identified for the 2018 performance period is finalized. These measures are identified on the next slide.
- Topped out measures will only be removed after a review of performance and additional considerations.
- Topped out policies **do not apply** to CMS Web Interface measures, but this will be monitored for differences with other submission options.

Quality Component (50%) 2018 Reporting

More On Topped Out Measures

What is the significance?

- A measure may be considered topped out if meaningful distinctions and improvement in performance can no longer be made.
- Topped out measures could have an impact on the scores for certain MIPS eligible clinicians, and provide little room for improvement for the majority of MIPS eligible clinicians.

Topped Out Measures:

The six topped out measures include the following:

- Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21)
- Melanoma: Overutilization of Imaging Studies in Melanoma.(Quality Measure ID: 224)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23)
- Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)
- Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359)
- Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52)

Basics:

- ***Change:* 10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

- *Change*: Cost performance category weight is **finalized at 10% for 2018.**
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

Cost Component (10%) 2018 Reporting

New for 2018: Performance Improvement Scoring

New: MIPS Scoring Improvement for Quality and Cost

- For Quality:
  - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
  - Improvement will be measured at the performance category level.
  - Up to 10 percentage points available in the Quality performance category.

- For Cost:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Up to 1 percentage point available in the Cost performance category.

Improvement Activities (15%)

Basics:

- **15%** of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple "yes" is all that is required to attest to completing an Improvement Activity

Number of Activities:

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- Burden Reduction Aim: MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

Patient-centered Medical Home:

- We finalized the term "recognized" is equivalent to the term "certified" as a patient centered medical home or comparable specialty practice.
- **50%** of practice sites* within a TIN or TINs that are part of a virtual group need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.

*We have defined practice sites as the *practice address that is available within the Provider Enrollment, Chain, and Ownership System (PECOS).*

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

CEHRT Requirements:

- Burden Reduction Aim: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

Measures and Objectives:

- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:

- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%

Advancing Care Information (25%) 2018 Reporting

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

Exceptions:

- Based on authority granted by the 21st Century Cures Act and MACRA , **CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category** for the **following reasons:**

Automatic reweighting:

  - Hospital-based MIPS eligible clinicians;
  - Non-Patient Facing clinicians;
  - Ambulatory Surgical Center (ASC)— based MIPS eligible clinicians, finalized retroactive to the transition year;
  - Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists

Reweighting through an approved application:

  - **New hardship exception for clinicians in small practices** (15 or fewer clinicians);
  - New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
  - Significant hardship exceptions—CMS will not apply a 5-year limit to these exceptions;

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and future years.
- Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19).

Advancing Care Information (25%) 2018 Reporting (Cont'd)

Scoring for 2018

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

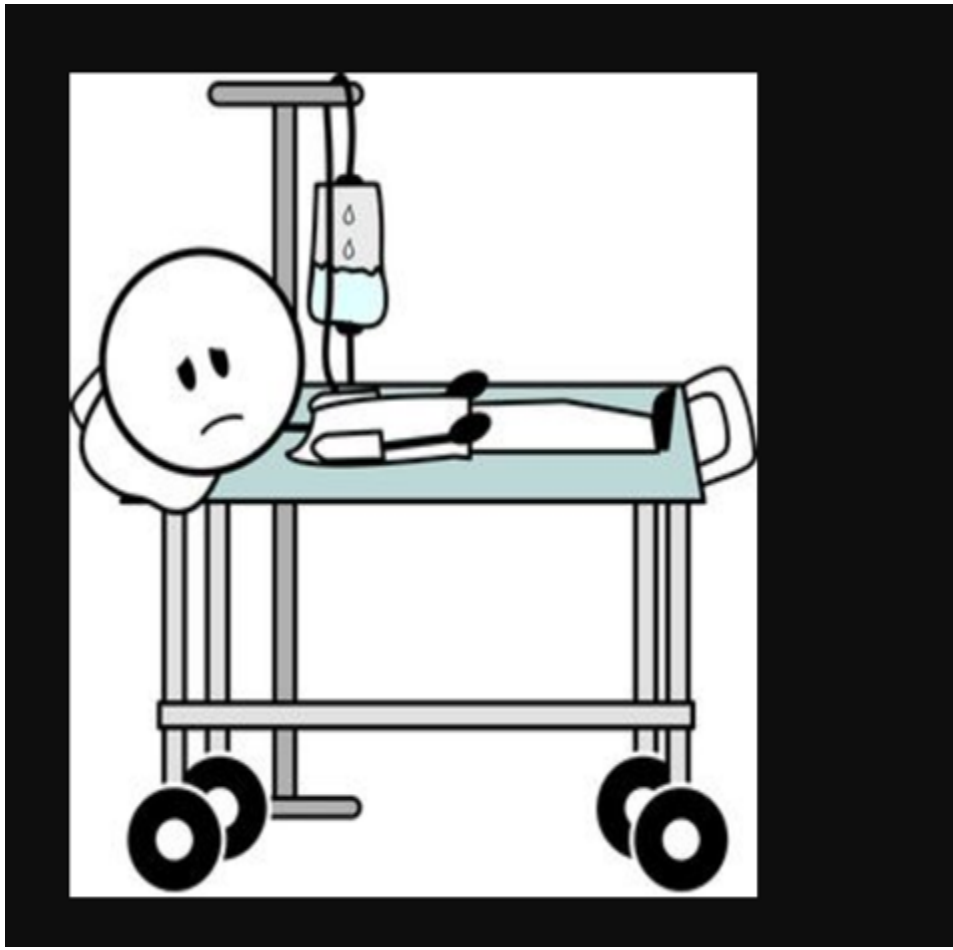
Final Score 2017	Payment Adjustment 2019
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	• Neutral payment adjustment
3.76-14.99	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

Final for 2018: Complex Patients

- Apply an adjustment of UP TO 5 points to the final score by adding the average Hierarchical Conditions Category (HCC) risk score to the final score.
- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus. .



FINAL for 2018: Small Practices

- Adjust the final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians) by adding 5 points, so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
- Add **5 additional points** for small practices to the final score.

Accommodations for Small Practices

CMS estimates 81.2% of EPs in practices of 1-15 will experience positive or neutral adjustments in 2020

In effect for 2017

- Pick your pace transition
- Low-volume threshold $30K/100 patients
- Reduced IA reporting
- $100 million in grants for technical assistance via QIOs and regional health improvement collaboratives

Finalized for 2018

- Low-volume threshold raised to $90K/ 200 patients
- Reduced IA reporting continued
- Technical assistance grants continued
- Virtual groups created
- ACI hardship exemption for small practices
- Bonus points added to final score for small practices

Facility-Based Measurement

New: Facility-based Measurement

Please note:

- Facility-based measurement policies are finalized, but with a **1-year delay to Year 3** (2019).

What you need to know:

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Voluntary facility-based scoring mechanism will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.
- Eligible as group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- Measures will be based on Hospital VBP for quality and cost measures.
- Scores will be derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score into a MIPS quality performance category and cost performance category score.

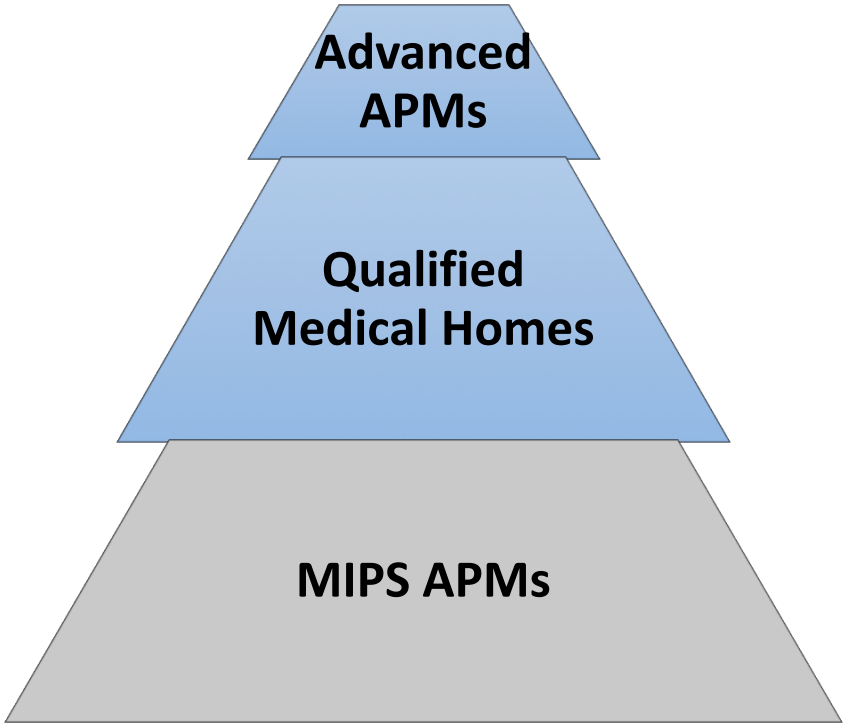
2018 Final Rule

QPP Year 2

Advanced Alternative Payment Models

APMs Participation Options 2017-2018

- **"Advanced" APMs** have greatest risks and offer potential for greatest rewards
- **Qualified Medical Homes** have different risk structure but otherwise will be treated as Advanced APMs
- **MIPS APMs** receive favorable MIPS scoring
- **Physician-focused APMs** are under development



- In the Year 1 Final Rule CMS established a general financial risk standard, applicable to all APMs, and a separate financial risk standard for Medical Home Models.
- CMS also finalized general nominal amount standards and a specific Medical Home Model nominal amount standard as part of those financial risk standards.

General Nominal Amount Standard
The total amount of that risk must be equal to at least either:

- 8% of the average estimated total Medicare Parts A and B revenues participating APM Entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.

Medical Home Model Nominal Amount Standard
The total amount of risk under a Medical Home Model must be at least the following amounts:

- 2.5% of estimated average total Medicare Parts A and B revenue (2017)
- 3% of estimated average total Medicare Parts A and B revenue (2018)
- 4% of estimated average total Medicare Parts A and B revenue (2019)
- 5% of estimated average total Medicare Parts A and B revenue (2020 and later)

In the Year 2, CMS finalized changes to these Advanced APM financial risk and nominal amount standards.

2018: Revenue At Risk

MIPS APMs

Criteria

- APM entity participates in a model under an agreement with CMS
- Entity includes at least one MIPS eligible clinician on a participant list
- Payment incentives based on performance on cost and quality measures (either on entity or individual clinician level)

2017 qualified models

- MSSP Track 1 counts

Advanced APM benefits do not apply

- Must participate in MIPS to receive any favorable payment adjustments
- Do not qualify for 5% APM bonus payments 2019-2024
- Not eligible for higher baseline annual updates beginning 2026

Other benefits

- 2017 MIPS APMs receive full Improvement Activities credit (could vary in future years)
- Models have simplified MIPS reporting
- APM-specific rewards (e.g., shared savings, guaranteed payments)
- Eligible for annual MIPS bonuses, which continue indefinitely (vs. 6 years for 5% APM bonuses)

MIPS APMs: All Advanced APMs below threshold PLUS

ACO Track 1

(438, 91% of total)

Oncology Care Model Track 1

Comprehensive ESRD Care Model

1-sided risk

The MACRA statute created two pathways to allow eligible clinicians to become QPs.

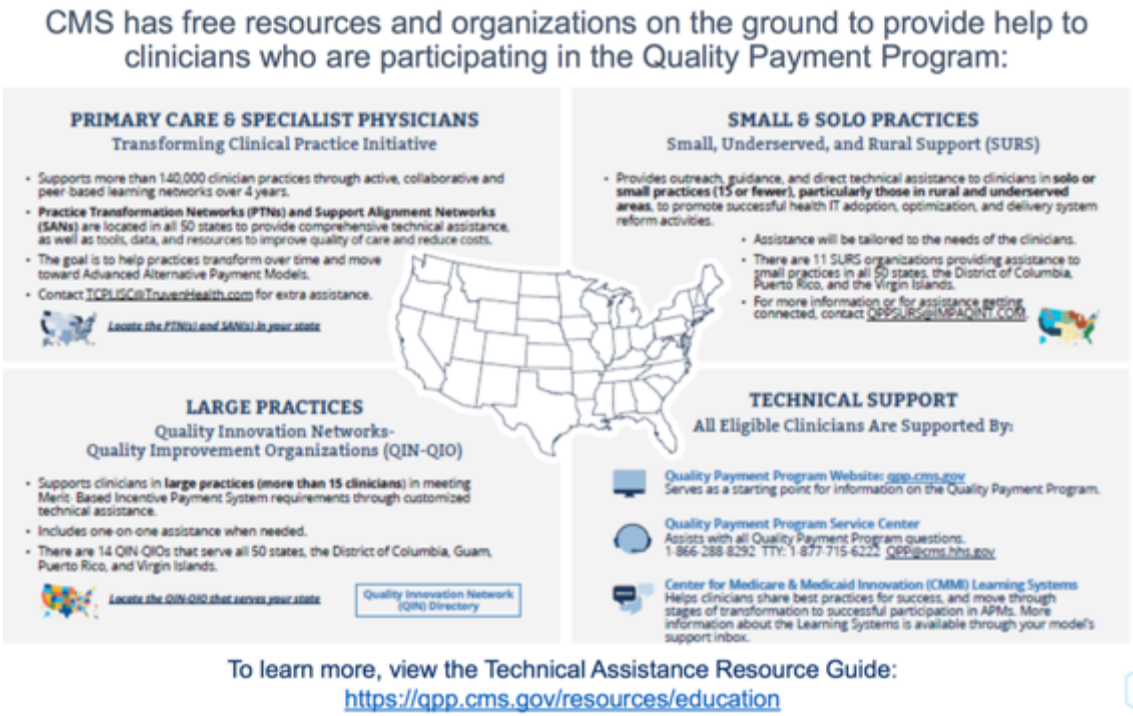
Medicare Option

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.

All-Payer Combination Option

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in Advanced APMs within Medicare fee-for-service, **AND** Other Payer Advanced APMs offered by other payers.

All Payer Proposal for APMs 2019



CMS Resources for MIPS & APMS

Coding 2018

CPT 2018 for Hem-Onc

- E/M Coding
  - Changes from Medicare 2017:
    - For cognitive-assessment services, report **99483** instead of **G0505**.
    - For collaborative care management (CoCM) services, report **99492**, **99493** and **99494** in place of **G0502**, **G0503** and **G0504**.
    - For care management-focused behavioral health integration (BHI), report **99484** instead of **G0507**.
- Take a look at additional details for each of the new codes:
  - **99483** (Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home). New cognitive-assessment code 99483 requires 10 reporting elements when the code debuts in 2018, just as G0505 did in 2017. However, note that the full CPT description of the code provides some clarity on the amount of time you're expected to spend with a patient. "Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver,"
  - **99492** (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional).
  - **99493** (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities).
  - **99494** (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities).
  - **99484** (Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month)

CPT Coding 2018

- Observation Services
  - **Four observation E/M code descriptor changed**. You'll find a slight change to the verbiage of one discharge and three initial observation care E/M codes, **99217-99220**, as the CPT update adds the term "outpatient hospital" to describe the observation status in question. For example, the descriptor for 99217 now reads, "this code is to be utilized to report all services provided to a patient on discharge from *outpatient hospital* 'observation status.'"

CPT Code Changes 2018

- Radiation/Breast Surgery
  - **Add-on code 19294 has been added to report preparation of tumor cavity** and placement of a radiation therapy applicator for intraoperative radiation therapy. The code is to be reported in addition to partial mastectomy procedures.
- Bone Marrow Biopsy
  - For diagnostic bone marrow aspiration, report revised code **38220**; when it's for a biopsy, report **38221**. When an aspiration is both diagnostic and a biopsy, report new code **38222**
  - **G0364 is deleted as of 12/31/2017**

CPT Coding 2018

- **Code 77422 Marked for Deletion**
  - Code 77422, *High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking,* will be deleted due to low utilization.
  - Through the efforts of ACR and others, the high energy neutron radiation treatment delivery code77423 will be retained and not deleted as had been suggested.

CPT Coding Changes 2018

- Vaccines--two additional flu-vaccine codes to choose from in 2018, Both codes relate to quadrivalent injections:
  - **90756** (Influenza virus vaccine, quadrivalent [ccIIV4], derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use).
  - **90682** (Influenza virus vaccine, quadrivalent [RIV4], derived from recombinant DNA, hemagglutinin [HA] protein only, preservative and antibiotic free, for intramuscular use).
  - **90750** (Shingles vaccine), in the CPT book for the first time, even though the AMA approved the code in 2016 and it became effective Jan. 1, 2017

HCPCS 2017: Modifiers

HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
JG	Drug or biological acquired with 340b drug pricing program discount	340b acquired drug
QQ	Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional	Qualified cdsm consulted
TB	Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes	Tracking 340b acquired drug
X1	Continuous/broad services: for reporting services by clinicians, who provide the principal care for a patient, with no planned endpoint of the relationship; services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role; reporting clinician service examples include, but are not limited to: primary care, and clinicians providing comprehensive care to patients in addition to specialty care	Continuous/broad services
X2	Continuous/focused services: for reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed with no planned endpoint to the relationship; reporting clinician service examples include but are not limited to: a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services	Continuous/focused services
X3	Episodic/broad servies: for reporting services by clinicians who have broad responsibility for the comprehensive needs of the patient that is limited to a defined period and circumstance such as a hospitalization; reporting clinician service examples include but are not limited to the hospitalist's services rendered providing comprehensive and general care to a patient while admitted to the hospital	Episodic/broad services
X4	Episodic/focused services: for reporting services by clinicians who provide focused care on particular types of treatment limited to a defined period and circumstance; the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention; reporting clinician service examples include but are not limited to, the orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period	Episodic/focused services
X5	Diagnostic services requested by another clinician: for reporting services by a clinician who furnishes care to the patient only as requested by another clinician or subsequent and related services requested by another clinician; this modifier is reported for patient relationships that may not be adequately captured by the above alternative categories; reporting clinician service examples include but are not limited to, the radiologist's interpretation of an imaging study requested by another clinician	Svc req by another clinician

HCPCS Codes: C-codes 1/1/2018

C9014	Injection, cerliponase alfa, 1 mg	Injection, cerliponase alfa
C9015	Injection, c-1 esterase inhibitor (human), haegarda, 10 units	C-1 esterase, haegarda
C9016	Injection, triptorelin extended release, 3.75 mg	Inj, triptorelin ext rel
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Inj, daunorubicin-cytarabine
C9028	Injection, inotuzumab ozogamicin, 0.1 mg	Inj. inotuzumab ozogamicin
C9029	Injection, guselkumab, 1 mg	Injection, guselkumab
C9488	Injection, conivaptan hydrochloride, 1 mg	Conivaptan hcl
C9492	Injection, durvalumab, 10 mg	Injection, durvalumab
C9493	Injection, edaravone, 1 mg	Injection, edaravone

HCPCS Codes 2018: J-codes

J0565	Injection, bezlotoxumab, 10 mg	Inj, bezlotoxumab, 10 mg
J0604	Cinacalcet, oral, 1 mg, (for esrd on dialysis)	Cinacalcet, esrd on dialysis
J0606	Injection, etelcalcetide, 0.1 mg	Inj, etelcalcetide, 0.1 mg
J1428	Injection, eteplirsen, 10 mg	Inj, eteplirsen, 10 mg
J1555	Injection, immune globulin (cuvitru), 100 mg	Inj cuvitru, 100 mg
J1627	Injection, granisetron, extended-release, 0.1 mg	Inj, granisetron, xr, 0.1 mg
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Makena, 10 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Inj hydroxyprogst capoat nos
J2326	Injection, nusinersen, 0.1 mg	Inj, nusinersen, 0.1mg
J2350	Injection, ocrelizumab, 1 mg	Injection, ocrelizumab, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg	Ustekinumab, iv inject, 1 mg
J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.	Inj, afstyla, 1 i.u.
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	Inj, kovaltry, 1 i.u.
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg	Kyleena, 19.5 mg
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	Aminolevulinic acid, 10% gel
J9022	Injection, atezolizumab, 10 mg	Inj, atezolizumab,10 mg
J9023	Injection, avelumab, 10 mg	Injection, avelumab, 10 mg
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Gemtuzumab ozogamicin 0.1 mg
J9285	Injection, olaratumab, 10 mg	Inj, olaratumab, 10 mg
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	Tisagenlecleucel car-pos t

HCPCS Codes 2018--Deleted

C9140	Injection, factor viii (antihemophilic factor, recombinant) (afstyla), 1 i.u.	Afstyla factor viii recomb
C9483	Injection, atezolizumab, 10 mg	Injection, atezolizumab
C9484	Injection, eteplirsen, 10 mg	Injection, eteplirsen
C9485	Injection, olaratumab, 10 mg	Injection, olaratumab
C9486	Injection, granisetron extended release, 0.1 mg	Inj, granisetron ext
C9487	Ustekinumab, for intravenous injection, 1 mg	Ustekinumab iv inj, 1 mg
C9489	Injection, nusinersen, 0.1 mg	Injection, nusinersen
C9490	Injection, bezlotoxumab, 10 mg	Injection, bezlotoxumab
C9491	Injection, avelumab, 10 mg	Injection, avelumab
C9494	Injection, ocrelizumab, 1 mg	Injection, ocrelizumab
J1725	Injection, hydroxyprogesterone caproate, 1 mg	Hydroxyprogesterone caproate
J9300	Injection, gemtuzumab ozogamicin, 5 mg	Gemtuzumab ozogamicin inj
P9072	Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit	Plate path red/rapid bac tes
Q9984	Levonorgestrel-releasing intrauterine contraceptive system (kyleena), 19.5 mg	Kyleena, 19.5 mg
Q9985	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Inj hydroxyprogst capoat nos
Q9986	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Makena, 10 mg
Q9987	Pathogen(s) test for platelets	Pathogen test for platelets
Q9988	Platelets, pheresis, pathogen-reduced, each unit	Platelets, pathogen reduced
Q9989	Ustekinumab, for intravenous injection, 1 mg	Ustekinumab, iv inject,1 mg

Thank You!!!