2019
Medicare Physician
Reimbursement
Updates
Welcome

- Thank you for joining today’s 2019 Medicare Physician Fee Schedule webinar
- Webinar materials will be available after the meeting ends
Questions?

- Please submit questions by clicking on the Chat panel from the down arrow on the Webex tool bar (at the top of the screen):

  1. Open the Chat panel
  2. Send to: David Harter (Host)
  3. Type your question in the text box and hit “send”

Additional questions after the webinar can be sent to sybil.green@asco.org
Today’s Speakers

- **Stephen Grubbs, MD, FASCO**
  - Vice President
  - Clinical Affairs

- **Sybil Green, JD, RPh, MHA**
  - Director, Coverage and Reimbursement
  - Policy and Advocacy

- **Brian Bourbeau**
  - Associate Director, Business Metrics and Analysis
  - Clinical Affairs

- **Karen Hagerty, MD**
  - Associate Director, Quality and HIT Policy
  - Policy and Advocacy

- **Allison Hirschorn**
  - Coding and Reimbursement Specialist
  - Clinical Affairs
2019 Medicare Physician Reimbursement Updates-Webinar Overview

Final rules for Physician Participation and Reimbursement for 2019 have been published.

Today’s Webinar will focus on these updates:

- Medicare Physician Fee Schedule
- Quality Payment Program
- Hospital Outpatient Prospective Payment System
2019 Medicare Physician Fee Schedule

Final Payment Rates Formula Updates
Physician Reimbursement and Adjustments

Adjustments

Final Reimbursement
Summary: 2019 MPFS Proposed Policies and Changes

- Projected 4% reimbursement cut for Hematology/Oncology Specialty
- Projected 2% reimbursement cut for Radiation/Oncology Specialty
- Changes in Evaluation and Management Code Payment
- Adjustment to Add-On Payment for Part B Drugs Paid through Wholesale Acquisition Cost Methodology
- Payment Rates under the Medicare Physician Fee Schedule for Non-Excepted Items and Services Furnished in Non-Excepted Hospital Outpatient Provider-Based Departments
- Addition of New Technology-Based Patient Care Codes
- Implementation of New Survey Data Set to Define Equipment and Supply Costs
ASCO Intense Advocacy

- Direct outreach TO and FROM HHS leadership
- Stakeholder meetings with HHS and CMS
- Technical/Modeling Discussion with CMS staff
- Outreach to White House and OMB
- Formal Comment
- State Affiliate letters
- In-person meetings
- Coalition sign-on
- AMA led letter
- Support for Hill letter

Concerns With 2019 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule
Clifford A. Hudis, MD, FACP, FASCO
@CliffordHudis
Sep 11, 2018
2019 MPFS Changes – Final Rule

- E/M Code Consolidation and Reimbursement Reduction
- E/M Documentation Changes
- Adjustment to Add-On Payment for New Part B Drugs
- Phased-in Reduction for Misvalued Codes
- Implementation of New Survey Data Set to Define Equipment and Supply Costs
- Addition of New Technology-Based Patient Care Codes
- Other Drug Administration Code Changes
- Projected 1% reimbursement cut for Hematology/Oncology Specialty
Projected reimbursement cuts for Oncology

Projected: -1% Hematology/Oncology and -1% Radiation Oncology

- Includes:
  - Changes related to 2019 conversion factor
  - Changes in work, malpractice and practice expense RVUs
  - Phased-in drug administration changes
Phased-in drug administration changes

- Identified as misvalued codes in 2017
- Reductions implemented in 2018
  - Max 19% per year
- 2019 Reductions
  - 96374 inj iv Push (19%)
  - 96375 inj iv addon (16%)
  - 96360 hydration iv infusion init (19%; 7% in 2020)
  - 96372 inj sc/im (19%; 6% in 2020)
Changes in work, malpractice and practice expense RVUs

Proposed changes to Practice Expense Payment
- New indirect PE category solely for office visits
- Overrides current methodology
- Treats office E/M as separate Medicare Designated Specialty
- Result: exclusion of indirect PE for office visits for certain specialties, causing large payment changes for some specialties

For Oncology, this would have impacted drug admin, resulting in greater than 10% reduction for chemotherapy services.

CMS will NOT implement this proposed policy change.

There are slight changes to practice expense due to new specialties added.
Evaluation and Management Changes

Streamlining Documentation Requirements

Evaluation and Management Code Consolidation
- Blended Rates
Evaluation and Management Documentation Requirements

Rationale:
- Streamline documentation and reduce clinician burden
- Outdated code set, which does not reflect
  - meaningful and appropriate differences in patient complexity and care
  - changes in technology and changes in electronic medical record requirements
  - Changes in care delivery
- Redundant
2019 Evaluation and Management Documentation Requirements

- Physicians can use 1995 or 1997 guidelines
- History and Exam may focus on what has changed since the last visit
- No longer required to document medical necessity of home visit in lieu of office visit
- Physicians may review and verify information entered by other staff
2019 Evaluation and Management Documentation Requirements

History and Exam

Established Patient

- Relevant information already in Medical Record
- Practitioner reviews previous information
- Update as needed
- Focus on what has changed since the last visit
- No need to re-record

Chief Complaint and History

New and Established Patients

- Relevant information already in Medical Record by ancillary staff or beneficiary
- Practitioner reviews information
- Practitioner verifies information

* Practitioners do have the option to continue the current process of entering, re-entering, and bringing forward information.
E/M code consolidation and blended rates - **Delayed**

**EFFECTIVE DATE:** January 1, 2021

Payment, coding and Additional Documentation Changes

E/M Code Consolidation and New Payment Rates

- Office and outpatient E/M visits
- Consolidates 5 existing E/M visit code levels into 3 levels
  - Single rate for levels 2 through 4
  - Maintaining rate for level 5
- New add-on codes for level 2-4 visits
  - Primary care
  - Certain non-procedural specialized medical care
  - Extended visit add-on code
E/M code consolidation and blended rates - **Delayed**

**EFFECTIVE DATE:** January 1, 2021

Payment, coding and Additional Documentation Changes

**E/M Documentation**
- For levels 2 through 5
  - Providers have a choice in documentation
  - Current framework
    - Minimum level 2 documentation
  - Medical decision-making only
    - Minimum level 2 documentation
  - Face-to-face time with patient
    - Medical necessity
## 2021 E/M code consolidation and blended rates

<table>
<thead>
<tr>
<th>Level</th>
<th>Established Patient</th>
<th>New Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CY 2018 Payment</td>
<td>Proposed Payment</td>
</tr>
<tr>
<td>1</td>
<td>$22</td>
<td>$24</td>
</tr>
<tr>
<td>2</td>
<td>$45</td>
<td>$90 (up to $103 with add-ons)</td>
</tr>
<tr>
<td>3</td>
<td>$74</td>
<td>$110</td>
</tr>
<tr>
<td>4</td>
<td>$109</td>
<td>$167</td>
</tr>
<tr>
<td>5</td>
<td>$148</td>
<td>$148</td>
</tr>
</tbody>
</table>

Proposed Payment based on CY2019 proposed RVU and CY2018 Payment Rate
## 2021 Documentation Requirements Using Time

<table>
<thead>
<tr>
<th>Code</th>
<th>Required Time (Minutes)</th>
<th>Estimated Payment</th>
<th>Code</th>
<th>Required Time (Minutes)</th>
<th>Estimated Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10</td>
<td>$90</td>
<td>99212 extended (+GPR01)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>$90</td>
<td>99213 extended (+GPR01)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>$90</td>
<td>99214 extended (+GPR01)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>$148</td>
<td>99215 prolonged (+99354 -5)</td>
<td>70+</td>
<td>$281+</td>
</tr>
</tbody>
</table>
E/M code consolidation and blended rates

2021 Estimated Impact for Office/Outpatient Based E/M Visits

CMS estimates -1% to -2% as a result of blended rates for Hematology/Oncology
Add-on Codes Using Time

Add-on payments for Complex Visits

- $67 adjustment
- Office visits lasting more than 30 minutes

Beyond office visit

Oncologist reporting a level 2-4 E/M visit and spending 30-69 minutes with a patient would be paid $167.

Report:
(99212-99214) + (GPRO1)

$90 + $67 = $167
Proposed Add-on Codes and Adjustments

Add-on payments for Complex Visits

- Office visits lasting more than 30 minutes Beyond office visit

Oncologist reporting a level 5 E/M visit and spending more than 60 minutes with a patient would be paid $215.

Report:
(99215) + (99354-5)

$148 + $133 = $281+
Multiple Procedure Payment Reduction

Proposed 50% reduction for same day services

- Least expensive procedure or visit
- Same physician or practice
- Separately identifiable E/M visit

*CMS will NOT implement this proposed policy change.*
2021 CPT/RUC Workgroup on Evaluation and Management

- CMS intends to propose two basic payment rates
  - Straightforward visit
  - Complex visits
- CMS intends to propose new add on codes for primary care and inherently complex specialty E/M visits
- CMS will consider input from CPT and RUC, as well as the physician community
- AMA has established a workgroup to work on the coding and valuation ahead of 2021 proposals and implementation
2019 Medicare Physician Fee Schedule

ASCO Preliminary Impact Analysis - Final Rule
### ASCO Model: Drug Administration

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>2018 PE RVU</th>
<th>2019 PE RVU</th>
<th>2018 Allowed Charges</th>
<th>2019 Allowed Charges</th>
<th>Change in Allowed Charges</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360</td>
<td>1.13</td>
<td>0.88</td>
<td>6,973,845</td>
<td>5,658,911</td>
<td>(1,314,934)</td>
<td>-18.9%</td>
</tr>
<tr>
<td>96361</td>
<td>0.29</td>
<td>0.28</td>
<td>5,446,158</td>
<td>5,310,392</td>
<td>(135,766)</td>
<td>-2.5%</td>
</tr>
<tr>
<td>96365</td>
<td>1.81</td>
<td>1.77</td>
<td>42,341,874</td>
<td>41,565,378</td>
<td>(776,496)</td>
<td>-1.8%</td>
</tr>
<tr>
<td>96366</td>
<td>0.43</td>
<td>0.42</td>
<td>7,323,482</td>
<td>7,211,924</td>
<td>(111,558)</td>
<td>-1.5%</td>
</tr>
<tr>
<td>96367</td>
<td>0.68</td>
<td>0.67</td>
<td>42,134,715</td>
<td>41,700,743</td>
<td>(433,972)</td>
<td>-1.0%</td>
</tr>
<tr>
<td>96368</td>
<td>0.41</td>
<td>0.41</td>
<td>2,472,209</td>
<td>2,474,536</td>
<td>2,328</td>
<td>0.1%</td>
</tr>
<tr>
<td>96372</td>
<td>0.40</td>
<td>0.29</td>
<td>27,245,539</td>
<td>22,104,379</td>
<td>(5,141,160)</td>
<td>-18.9%</td>
</tr>
<tr>
<td>96374</td>
<td>1.11</td>
<td>0.90</td>
<td>4,138,526</td>
<td>3,478,608</td>
<td>(659,918)</td>
<td>-15.9%</td>
</tr>
<tr>
<td>96375</td>
<td>0.40</td>
<td>0.36</td>
<td>20,500,666</td>
<td>18,915,102</td>
<td>(1,585,563)</td>
<td>-7.7%</td>
</tr>
<tr>
<td>96401</td>
<td>2.01</td>
<td>1.98</td>
<td>25,529,165</td>
<td>25,219,891</td>
<td>(309,274)</td>
<td>-1.2%</td>
</tr>
<tr>
<td>96402</td>
<td>0.67</td>
<td>0.67</td>
<td>4,959,522</td>
<td>4,964,272</td>
<td>4,751</td>
<td>0.1%</td>
</tr>
<tr>
<td>96409</td>
<td>2.79</td>
<td>2.74</td>
<td>11,460,874</td>
<td>11,288,344</td>
<td>(172,529)</td>
<td>-1.5%</td>
</tr>
<tr>
<td>96411</td>
<td>1.43</td>
<td>1.42</td>
<td>10,131,352</td>
<td>10,080,492</td>
<td>(50,860)</td>
<td>-0.5%</td>
</tr>
<tr>
<td>96413</td>
<td>3.66</td>
<td>3.61</td>
<td>183,462,297</td>
<td>181,383,260</td>
<td>(2,079,037)</td>
<td>-1.1%</td>
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<tr>
<td>96415</td>
<td>0.67</td>
<td>0.65</td>
<td>17,936,535</td>
<td>17,545,872</td>
<td>(390,663)</td>
<td>-2.2%</td>
</tr>
<tr>
<td>96416</td>
<td>3.80</td>
<td>3.70</td>
<td>5,580,838</td>
<td>5,436,806</td>
<td>(144,031)</td>
<td>-2.6%</td>
</tr>
<tr>
<td>96417</td>
<td>1.68</td>
<td>1.67</td>
<td>24,856,262</td>
<td>24,756,092</td>
<td>(100,169)</td>
<td>-0.4%</td>
</tr>
<tr>
<td>96521</td>
<td>3.88</td>
<td>3.84</td>
<td>1,721,426</td>
<td>1,706,748</td>
<td>(14,678)</td>
<td>-0.9%</td>
</tr>
<tr>
<td>96523</td>
<td>0.73</td>
<td>0.71</td>
<td>5,572,278</td>
<td>5,437,085</td>
<td>(135,192)</td>
<td>-2.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3.39</td>
<td>3.28</td>
<td>450,452,636</td>
<td>436,901,412</td>
<td>(13,551,224)</td>
<td>-3.0%</td>
</tr>
</tbody>
</table>

**Notes:**
- This shows the impact of the practice expense RVU changes in the drug administration codes
- Uses preliminary 2017 data available on data.cms.gov
- Use RVU values contained with the addendum
### ASCO Model: Other Changes >$20k

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>2018 Allowed Charges</th>
<th>2019 Allowed Charges</th>
<th>Change in Allowed</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>88185</td>
<td>13,061,353</td>
<td>10,615,551</td>
<td>(2,445,802)</td>
<td>-18.7%</td>
</tr>
<tr>
<td>71250</td>
<td>2,128,591</td>
<td>2,037,042</td>
<td>(91,549)</td>
<td>-4.3%</td>
</tr>
<tr>
<td>71260</td>
<td>9,638,657</td>
<td>9,576,866</td>
<td>(61,791)</td>
<td>-0.6%</td>
</tr>
<tr>
<td>99195</td>
<td>6,529,863</td>
<td>6,468,982</td>
<td>(60,880)</td>
<td>-0.9%</td>
</tr>
<tr>
<td>G6013</td>
<td>1,885,953</td>
<td>1,836,037</td>
<td>(49,916)</td>
<td>-2.6%</td>
</tr>
<tr>
<td>G6012</td>
<td>1,678,020</td>
<td>1,631,408</td>
<td>(46,612)</td>
<td>-2.8%</td>
</tr>
<tr>
<td>85097</td>
<td>225,726</td>
<td>192,848</td>
<td>(32,877)</td>
<td>-14.6%</td>
</tr>
<tr>
<td>74160</td>
<td>643,483</td>
<td>669,338</td>
<td>25,856</td>
<td>4.0%</td>
</tr>
<tr>
<td>76872</td>
<td>83,853</td>
<td>110,500</td>
<td>26,647</td>
<td>31.8%</td>
</tr>
<tr>
<td>74178</td>
<td>2,139,846</td>
<td>2,186,794</td>
<td>46,948</td>
<td>2.2%</td>
</tr>
<tr>
<td>85390</td>
<td>55,898</td>
<td>114,065</td>
<td>58,167</td>
<td>104.1%</td>
</tr>
<tr>
<td>G6015</td>
<td>6,421,810</td>
<td>6,493,271</td>
<td>71,461</td>
<td>1.1%</td>
</tr>
<tr>
<td>74177</td>
<td>11,845,237</td>
<td>12,167,545</td>
<td>322,308</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

**Notes:**
- This shows the impact of the RVU changes in other codes
- Uses preliminary 2017 data available on data.cms.gov
- Use RVU values contained with the addendum
## ASCO Model: Summary

<table>
<thead>
<tr>
<th>Policies</th>
<th>Hematology (82)</th>
<th>Hematology/Oncology (83)</th>
<th>Medical Oncology (90)</th>
<th>Grand Total</th>
<th>Pct Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2018 Allowed Charges</strong></td>
<td>63,479,039</td>
<td>1,290,510,962</td>
<td>387,085,950</td>
<td>1,741,075,952</td>
<td>0.2%</td>
</tr>
<tr>
<td>Change to E&amp;M</td>
<td>59,435</td>
<td>2,737,483</td>
<td>727,014</td>
<td>3,523,932</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Change to 88185</td>
<td>(30,673)</td>
<td>(1,852,979)</td>
<td>(562,151)</td>
<td>(2,445,802)</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Mis-valued Drug Admin</td>
<td>(247,101)</td>
<td>(6,647,846)</td>
<td>(1,806,628)</td>
<td>(8,701,575)</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Other Drug Admin</td>
<td>(128,195)</td>
<td>(3,664,717)</td>
<td>(1,056,737)</td>
<td>(4,849,648)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Changes</td>
<td>9,225</td>
<td>6,250</td>
<td>(9,662)</td>
<td>5,812</td>
<td></td>
</tr>
<tr>
<td><strong>2019 Estimated Allowed Charges</strong></td>
<td>63,141,730</td>
<td>1,281,089,153</td>
<td>384,377,787</td>
<td>1,728,608,670</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Total Change</td>
<td>(337,309)</td>
<td>(9,421,809)</td>
<td>(2,708,164)</td>
<td>(12,467,282)</td>
<td></td>
</tr>
<tr>
<td>% Change</td>
<td>-0.5%</td>
<td>-0.7%</td>
<td>-0.7%</td>
<td>-0.7%</td>
<td></td>
</tr>
</tbody>
</table>
ASCO Model: Impact on Real Practices

PracticeNET Model for MPFS 2019 Proposed Rule
ASCO Model: Impact on Real Practices

PracticeNET Model for MPFS 2019 Final Rule
2019 Medicare Physician Fee Schedule

Final Policy Updates
Adjustment to Add-On Payment for Part B Drugs Paid through Wholesale Acquisition Cost Methodology

- New drugs coming to market
- During the first quarter, ASP is unavailable
- WAC based on manufacturer list price
- Does not include discounts and rebates
- WAC-based reimbursement would apply for a three-month period, until an ASP is established

Current Reimbursement: WAC + 6%
New Reimbursement: WAC + 3%
Non-Excepted Items/Services Furnished in Non-Excepted Hospital Outpatient Provider-Based Departments

New Payment Rates under the Medicare Physician Fee Schedule

Goal: Align overall payment amounts paid at off-campus hospital departments with physician practices

- Statutory requirement to pay for items and services furnished in off-campus provider-based departments under the appropriate reimbursement system
- MPFS finalized as appropriate payment system in 2017
- No longer eligible for payment under the Hospital Outpatient Prospective Payment System
- Paid non-facility PFS rate using “relativity adjuster”
- 40% of hospital outpatient system rate for the same code
- Professional component reimbursed at the facility rate PFS
Appropriate Use Criteria (AUC)

- Requires physicians to consult with AUC through a qualified decision support system for imaging services
  - Consulting with AUC precludes prior-authorization for imaging services
  - Voluntary participation through December 2019
  - Reportable on all technical and professionals claims for imaging services
  - Educational and operations testing beginning in 2020
    - Claims paid with/without AUC information
- Final Rule
  - Including independent diagnostic testing facilities
  - AUC program-specific Hardship exemptions
  - Development of codes and modifiers to report AUC information
  - Allow non-physicians to consult with AUC
Addition of New Technology-Based Patient Care Codes

Increased access for beneficiaries to physician services furnished via communication technology

- New HCPCS codes
- Not Medicare telehealth services
- Discrete services involving communication technology
- Brief, non-face-to-face check in
  - Assesses whether an office visit is necessary
  - Initiated by established patients
  - Real-time evaluation
- Remote evaluation of pre-recorded patient information
  - Photos or videos provided by the patient
  - Separately billed if there is no associated E/M visit
New HCPCS Codes for Telehealth and Telecommunication Services

Brief Communication Technology Based Service, e.g. Virtual Check in

- G2012
- Physician/other qualified health care professional
- Report E/M services provided to established patient
  - Unrelated to E/M service provided within 7 days
  - Cannot lead to E/M service or procedure within 24 hours
- Requires 5-10 minutes of Medical Discussion
New HCPCS Codes for Telehealth and Telecommunication Services

Remote Evaluation of Pre-Recorded Patient Information

- G2010
- Remote evaluation of recorded video and/or images
  - Unrelated to E/M service provided within 7 days
  - Cannot lead to E/M service or procedure within 24 hours
- Established patient
- Includes interpretation and follow-up within 24 hours
Addition of New Technology-Based Patient Care Codes

Interprofessional Consultations

- Reimbursement for consultation between practitioners
- Can replace face-to-face visit with consulting practitioner
- Consultation provided via:
  - Telephone, internet or EHR
- Requires verbal consent from beneficiary; recorded in EHR
New Codes for Telehealth and Telecommunication Services

Interprofessional Internet Consultation
- CPT codes 99451, 99452, 99446, 99447, 99448, and 99449
- “Interprofessional Telephone/Internet/Electronic Health Record Consultations”

ASCO Resources on New Codes
For additional information on the coding and reimbursement changes, a resource will be posted on “ASCO Practice Central”.
Questions about billing and coding can be sent to billingandcoding@asco.org
2019 Quality Payment Updates

Merit Based Incentive Payment System
and Alternative Payment Models
Overall MIPS Participation & Payment Adjustments

- Approximately **798,000 clinicians** will be MIPS eligible clinicians in the 2019 MIPS performance period
  - Increase of almost 148,000 from the estimate provided in the CY 2019 PFS proposed rule
- **NEW Eligible Clinicians:**
  - Physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals
- Maximum +/− **7% adjustment**
- **$390 million ↔ +$390 million**
- Positive MIPS payment adjustments will also include up to an additional **$500 million** for exceptional performance
## MIPS Reporting Requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>2018</th>
<th>%</th>
<th>2019</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Threshold</strong></td>
<td>15 Points</td>
<td>50</td>
<td>30 Points</td>
<td>45</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 Measures, including 1 outcome/high priority</td>
<td>50</td>
<td></td>
<td>• 6 measures, including 1 outcome/high priority</td>
<td>45</td>
</tr>
<tr>
<td>• Full calendar year</td>
<td></td>
<td></td>
<td>• Full calendar year</td>
<td></td>
</tr>
<tr>
<td>• 60% of all patients</td>
<td></td>
<td></td>
<td>• 60% of all patients</td>
<td></td>
</tr>
<tr>
<td><strong>ACI “Promoting Interoperability”</strong></td>
<td></td>
<td>25</td>
<td>• At least 90 days</td>
<td>25</td>
</tr>
<tr>
<td>• At least 90 days</td>
<td></td>
<td></td>
<td>• One measure set based on the required 2015 Edition CEHRT</td>
<td></td>
</tr>
<tr>
<td>• Hardship exemption for small practices</td>
<td></td>
<td></td>
<td>• Removal of base + performance scoring</td>
<td></td>
</tr>
<tr>
<td>• 2014 Edition CEHRT</td>
<td></td>
<td></td>
<td>• Added two new measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement</td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>• At least 90 days</td>
<td>15</td>
<td>• At least 90 days</td>
<td>15</td>
</tr>
<tr>
<td>• 1-4 activities</td>
<td></td>
<td></td>
<td>• Added 6 new Improvement Activities</td>
<td></td>
</tr>
<tr>
<td>• Reduced reporting for small/rural practices</td>
<td></td>
<td></td>
<td>• Modification of 5 existing Improvement Activities</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>• Full year; Calculated automatically by CMS</td>
<td>10</td>
<td>• 8 episode-based measures added to the list of Cost measures</td>
<td>15</td>
</tr>
<tr>
<td>• Total Per Capita Cost Medicare Spend per Beneficiary</td>
<td></td>
<td></td>
<td>• New Criterion: provide ≤ 200 covered services</td>
<td></td>
</tr>
<tr>
<td>Low-Volume Threshold Criteria</td>
<td>≤ $90,000 in Part B allowed charges, OR</td>
<td></td>
<td>• Opt-in if one or two, but not all, of the Low-volume threshold criterion are met or exceeded</td>
<td></td>
</tr>
<tr>
<td>• ≤ 200 Part B beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc.</td>
<td>• Virtual Groups added</td>
<td></td>
<td>• Facility-based reporting adopted</td>
<td></td>
</tr>
<tr>
<td>• Facility-based reporting proposed but not adopted</td>
<td></td>
<td></td>
<td>• Bonus points for small practices moved to quality performance category from overall score – must report on at least one quality measure to receive bonus</td>
<td></td>
</tr>
<tr>
<td>• Bonus points for small practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Facility-Based Scoring [NEW]

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicability</strong></td>
<td>Furnishes 75% or more of covered professional services in:</td>
<td>75% or more of the MIPS eligible clinician NPIs billing under the group’s TIN are eligible for facility-based measurement as individuals</td>
</tr>
<tr>
<td></td>
<td>• inpatient hospital (POS 21)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• on-campus outpatient hospital (POS 22)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• emergency room (POS 23)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Must have at least a single service billed with the POS code used for the inpatient hospital (21) or emergency room (23)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on claims for a period prior to the performance period</td>
<td></td>
</tr>
<tr>
<td><strong>Attribution</strong></td>
<td>Hospital at which they provide services to the most Medicare patients</td>
<td>Hospital at which a plurality of its facility-based clinicians are attributed</td>
</tr>
<tr>
<td></td>
<td>• Facility must have a Hospital VBP Program score for the applicable period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used</td>
<td></td>
</tr>
</tbody>
</table>
Facility-Based Scoring (cont’d)

Election
- Facility-based measurement is automatically applied to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who have a higher combined Quality and Cost score

Data Submission
- There are no data submission requirements for the Quality and Cost performance categories
- Must submit data in the Improvement Activities or Promoting Interoperability performance categories in order to be measured under facility-based measurement

Assigning MIPS Category Scores – Quality Performance and Cost Performance Categories
- Determine the percentile performance of the facility determined in the Hospital VBP program for the specified year
- Award a score associated with that same percentile performance in the MIPS Quality and Cost performance category scores for those clinicians who are not scored using facility-based measurement

Measures
- Measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians (FY 2020 for 2019 performance period)
Quality Performance Category
# New Terminology

<table>
<thead>
<tr>
<th><strong>Collection Type (&quot;What&quot;)</strong></th>
<th><strong>Submission Type (&quot;How&quot;)</strong></th>
<th><strong>Submitter Type (&quot;Who&quot;)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>eCQMs</td>
<td>Direct (computer-to-computer, e.g. API)</td>
<td>MIPS eligible clinician</td>
</tr>
<tr>
<td>MIPS Clinical Quality Measures (MIPS CQMs)</td>
<td>Log in and upload (form and manner specified by CMS, authenticated credentials)</td>
<td>Group</td>
</tr>
<tr>
<td>QCDR measures</td>
<td>Log in and attest (manually attest, form and manner specified by CMS, authenticated credentials)</td>
<td>Third party intermediary</td>
</tr>
<tr>
<td>Medicare Part B claims measures</td>
<td>Medicare Part B claims</td>
<td></td>
</tr>
<tr>
<td>CMS Web Interface measures</td>
<td>CMS Web Interface</td>
<td></td>
</tr>
<tr>
<td>CAHPS for MIPS survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative claims measures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CMS Web Interface**
### Multiple Collection Types Allowed

<table>
<thead>
<tr>
<th>Individual Eligible Clinicians:</th>
<th>Groups &amp; Virtual Groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS CQM;</td>
<td>MIPS CQM;</td>
</tr>
<tr>
<td>eCQM;</td>
<td>eCQM;</td>
</tr>
<tr>
<td>QCDR measures; and/or</td>
<td>QCDR measures; and/or</td>
</tr>
<tr>
<td>Medicare Part B claims measures (small practices only)</td>
<td>Medicare Part B claims measures (small practices only);</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface measures for large practices,*</td>
</tr>
</tbody>
</table>

If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring (does not apply to CMS Web Interface measures)

*EXCEPTION: CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures*
Change in Part B Claims Quality Measure Reporting

- Allowed for individuals in small groups (no change)
- Allowed for group reporting in small groups [NEW]
- No longer available for individual reporting in large groups [NEW]
High Priority & Outcome Measures

- **High Priority**
  - Outcome
  - Appropriate use
  - Patient safety
  - Efficiency
  - Patient experience
  - Care coordination
    - Opioid-related quality measure [NEW]

- **Outcome**
  - Intermediate outcome measures
  - Patient-reported outcome measures
Topped Out Measures

- In 2018, finalized a 4-year timeline for measure removal
- Extremely topped out status [NEW]
  - E.g. average mean performance within 98th-100th percentile range
  - May propose the measure for removal in the next rulemaking cycle
  - Would also consider retaining the measure if there are compelling reasons as to why it should not be removed
- Excluded topped out QCDR measures from 4-year timeline
  - When a QCDR measure reaches topped out status, as determined during the QCDR measure approval process, it may not be approved as a QCDR measure for the applicable performance period
Measures with Clinical Guideline Changes during the Performance Period

- CMS may suppress a measure without rulemaking
  - If new evidence leads to measure posing potential harm to patients
- CMS relying on measure stewards for notifications in changes to guidelines
- Will publish these measures when technically feasible, but no later than beginning of data submission period
- **Scoring impact:** CMS will subtract measure from quality score denominator
Validation (Scoring)

- Validation of measure availability & applicability
- Only for claims, MIPS CQMs or combination
- Validation process not applied to eCQMs, even if submitted by a registry
Promoting Interoperability (PI) Performance Category
# Promoting Interoperability 2019: Objectives, Measures & Scoring Methodology

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Prescribing</td>
<td>E-Prescribing</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><em>Bonus</em>: Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 (bonus)</td>
</tr>
<tr>
<td></td>
<td><em>Bonus</em>: Verify Opioid Treatment Agreement</td>
<td>5 (bonus)</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>20</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40</td>
</tr>
</tbody>
</table>
| Public Health & Clinical Data Exchange          | Report to two different public health agencies or clinical data registries for any of the following:  
|                                                 |   - Immunization Registry Reporting                                         | 10             |
|                                                 |   - Electronic Case Reporting                                              |                |
|                                                 |   - Public Health Registry Reporting                                       |                |
|                                                 |   - Clinical Data Registry Reporting                                       |                |
|                                                 |   - Syndromic Surveillance Reporting                                       |                |
Cost Performance Category
Cost Measures

- **Total Per Capita Cost (TPCC)**
  - Case minimum of 20
  - Attribution: Plurality of primary care services rendered by the clinician

- **Medicare Spending Per Beneficiary (MSPB)**
  - Case minimum of 35
  - Attribution: Plurality of Part B services billed during the index admission

- **Episode-based Measures (8) [NEW]**
  - Case minimum of 10 for procedural episodes and 20 for acute inpatient medical condition episodes
  - Attribution:
    1. For **procedural episodes**, attributed to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes)
    2. For **acute inpatient medical condition episodes**, attributed to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization
# Episode-Based Cost Measures

<table>
<thead>
<tr>
<th>Measure Topic</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td></td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td></td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
<td></td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td></td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute Inpatient Medical Condition</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td></td>
</tr>
</tbody>
</table>
Overall APM Participation & Payment Adjustments

- 165,000 - 220,000 clinicians will become Qualifying APM Participants (QP)
- Total lump sum APM incentive payments will be approximately $600-800 million
Select Advanced APM Highlights

- An Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT
  - As of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75%
- Extends the 8% revenue-based nominal amount standard for Advanced APMs and Other Payer Advanced APMs through performance year 2024
- Increases flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program
- Establishes a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement (or up to 5 years)
- Allowing QP determinations at the TIN level, in addition to the current options for determinations at the APM entity level and the individual level, in instances when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity
- Moving forward with allowing all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period
Hospital Outpatient Prospective Payment System
2019 Hospital Outpatient Prospective Payment System (HOPPS) Reimbursement (Proposed)

340B Drug Pricing Programs
ASP – 22.5%
• Extended to more off-campus provider-based hospital-affiliated clinics

Off-Campus Hospital Affiliated Providers
40% OPPS Rate
• MPFS Reimbursement
• Site Neutrality
• Extended Service Lines
HOPPS Final Rule

- 2019 Hospital Outpatient Prospective Payment System (HOPPS) final rule released November 2nd
- Update payments under the OPPS by 1.35%
  - Expected total payments increase of $5.8B relative to 2018
- NOT moving forward with a proposed policy to reduce reimbursement for excepted provider-based departments (PBD)
  - Items and services in clinical families of services that had not previously provided.
  - Will continue “to monitor the expansion of services in excepted off-campus PBDs.”
- Finalized cuts to 340B and site neutral payments
- ASCO opposes any cuts to resources for cancer care delivery
  - Cuts could diminish patient access to needed cancer care services.
Site Neutral Changes

- Phase in over two years
- Reduced payment for clinic visits in off campus PBDs (site neutral changes in Bipartisan Budget Act of 2015 did not previously apply)
- Estimated $380M in 2019 savings
  - will not be redistributed to hospitals.
Final HOPPS 340B Changes

- Extends the 2018 cut to the 340B Drug Pricing Program
  - Sales Price (ASP) +6 percent to ASP -22.5 percent
  - Now applies to previously exempt off-campus, provider-based hospital-affiliated clinics
Questions?

- Please submit questions by clicking on the Chat panel from the down arrow on the WebEx tool bar (at the top of the screen):
  1. Open the Chat panel
  2. Send to: David Harter
  3. Type your question in the text box and hit “send”

Additional questions after the webinar can be sent to: sybil.green@asco.org