

SNMMI Update: Appropriate Use Criteria (AUC) and Quality Payment Program (MIPS)

**Mid-Eastern Chapter of the Society of Nuclear Medicine
48th Annual Spring Meeting**

The HOTEL at Arundel Preserve in Hanover, MD

April 13-15, 2018

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Overview

- AUC – Background (PAMA Legislation - 2014)
- Q-PLE (Requirements and List)
- Q-CDSM (Requirements and List)
- MPFS Update – PAMA/AUC
- Update on MACRA/MIPS/QPP
- Update on AHCA, BCRA and ACA (Tax Reform Act 2017)
- Known Unknowns for PAMA and QPP
- Unknown Unknowns for PAMA and QPP



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AUC Background

Protecting Access to Medicare Act of 2014

Protecting Access to Medicare Act (PAMA) 2014

- On March 31, 2014, Congress passed the “Protecting Access to Medicare Act of 2014” (H.R. 4302)
 - Tied advanced diagnostics imaging services - physician reimbursement to appropriate use criteria (AUC).
 - **Ordering professionals (OP) will have to consult AUCs via a clinical decision support mechanism prior to ordering ADIS**, for help in determining whether an exam is clinically appropriate for a patient’s condition
 - Advanced Diagnostic Imaging Services are defined as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine (including positron emission tomography), and other diagnostic imaging services specified by the Secretary in consultation with physician specialty organizations and other stakeholders



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What are Appropriate Use Criteria (AUC)?

Appropriate Use Criteria (AUC)

Objective:

Identify patients who will most appropriately benefit from a procedure, thus resulting in a more effective and equitable allocation of healthcare resources.

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Be scientifically valid & evidence-based

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Be scientifically valid & evidence-based

Be based on publicly available studies that are published and reviewable by stakeholders

SNMMI AUC Development Project

- SNMMI modeled its AUC development process after the RAND/UCLA criteria and includes a systematic review of evidence followed by development of AUC for various common clinical scenarios using a modified Delphi approach
- This process is also consistent with the Institute of Medicine's standards for developing trustworthy clinical guidance documents
- The process included identification of relevant clinical scenarios, a systematic synthesis of available evidence, individual and group ratings of the scenarios using a formal consensus process, and drafting the final AUC document based on the group ratings and discussions
- To conduct independent and objective systematic review of the evidence, SNMMI has an ongoing contract with the Oregon Health and Science University's Evidence-based Practice center
- The primary purpose of these systematic reviews is to assess the diagnostic accuracy and comparative effectiveness of selected nuclear medicine procedures in clinical decision making and patient outcomes

Specialty Societies/Organizations Collaborating with SNMMI

- Alzheimer's Association
- European Association of Nuclear Medicine
- American Society of Clinical Oncology
- American College of Emergency Physicians
- American College of Radiology
- American Society of Hematology
- Society of Thoracic Surgeons
- American College of Chest Physicians
- American Gastroenterological Association
- American College of Nuclear Medicine
- Society for Pediatric Radiology
- Canadian Association of Nuclear Medicine
- North American Neuroendocrine Tumor Society
- Endocrine Society
- Society of Surgical Oncology
- National Comprehensive Cancer Network
- American College of Physicians
- World Conference on Interventional Oncology
- Radiological Society of North America
- Association of University Radiologists
- American Roentgen Ray Society
- American Neurogastroenterology and Motility Society
- American Board of Nuclear Medicine
- Canadian Cardiovascular Society
- Society of Cardiovascular Computed Tomography
- American College of Cardiology
- American Society for Radiation Oncology
- European Neuroendocrine Tumor Society
- World Molecular Imaging Society
- American Urological Association
- American Academy of Family Physicians
- American Thyroid Association
- American Head and Neck Society
- American Association of Clinical Endocrinology

Overview of SNMMI's AUC Development Process

Each AUC Committee will go through each of these steps to complete the needed development process

Overview of SNMMI's AUC Development Process

Multidisciplinary Expert
Panel Reports COI



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Identify Indications

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Identify Indications



Collect and Review
Evidence

Each AUC Committee will go through each of these steps to complete the needed development process

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Identify Indications

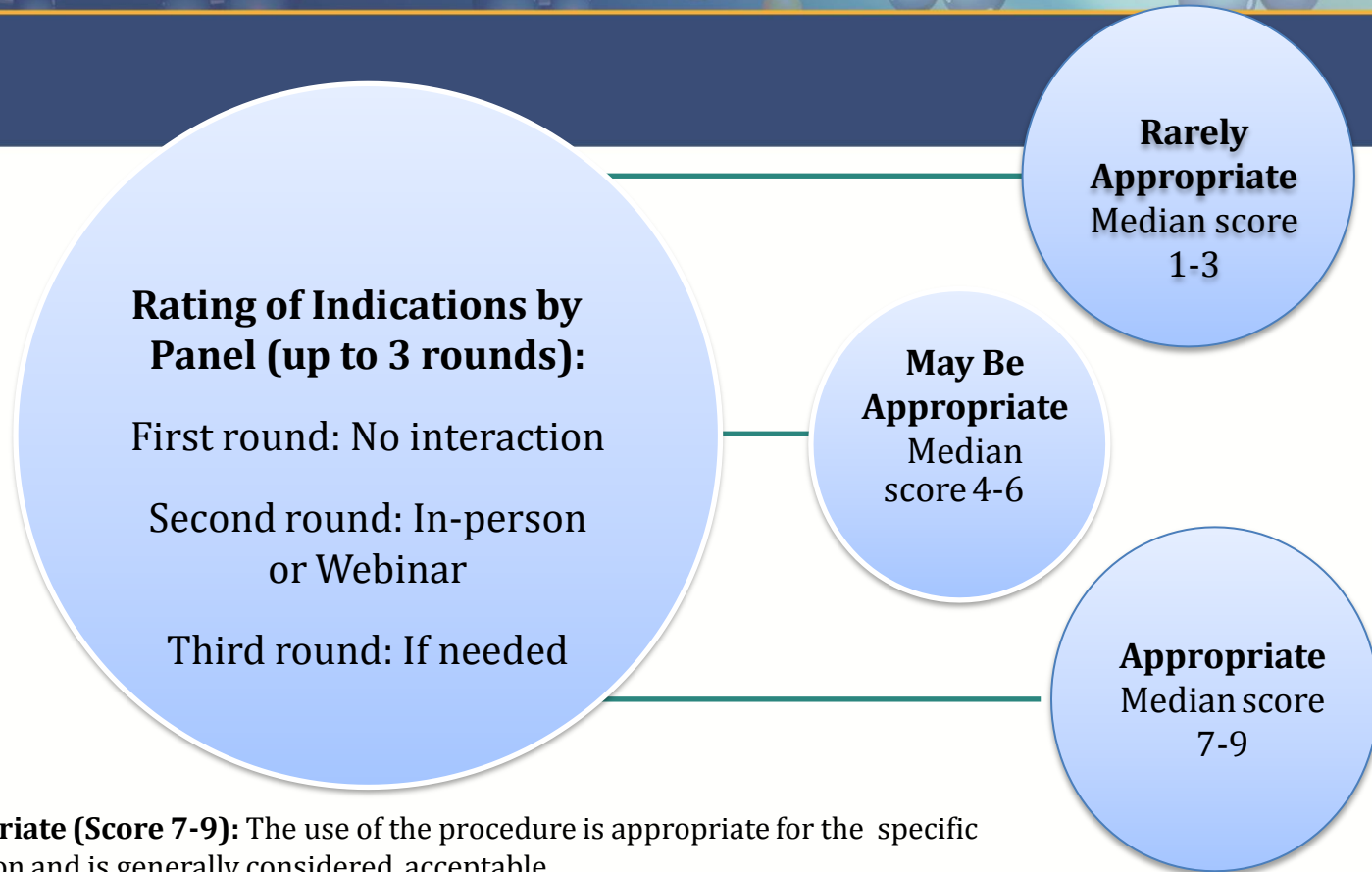


Collect and Review
Evidence



Rate/Score Clinical
Indications

Each AUC Committee will go through each of these steps to complete the needed development process



Appropriate (Score 7-9): The use of the procedure is appropriate for the specific indication and is generally considered acceptable.

May Be Appropriate (Score 4-6): The use of the procedure is uncertain for the specific indication, although its use may be appropriate and acceptable. Uncertainty implies that more research is needed to classify the indication definitively.

Rarely Appropriate (Score 1-3): Use of the procedure is inappropriate for the specific indication and generally is not considered acceptable.

Overview of SNMMI's AUC Development Process

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Identify Indications



Collect and Review
Evidence



Rate/Score Clinical
Indications



Write Document

Each AUC Committee will go through each of these steps to complete the needed development process

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Identify Indications



Collect and Review
Evidence



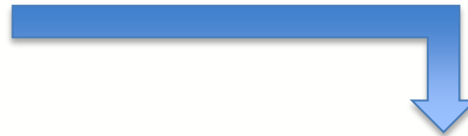
Rate/Score Clinical
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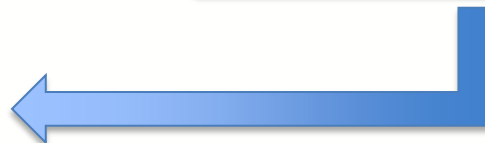
Write Document

Each AUC Committee will go through each of these steps to complete the needed development process

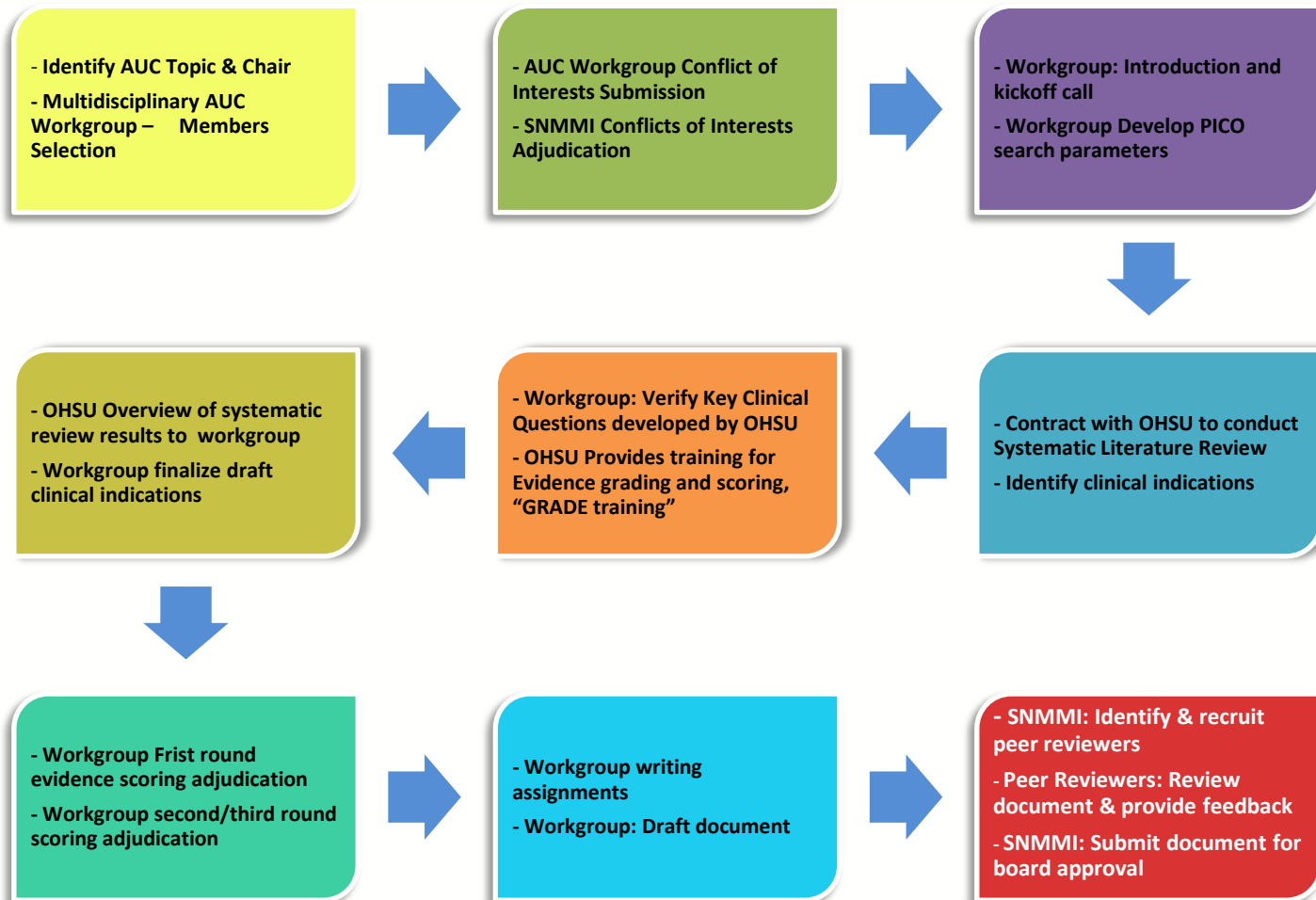
If cost and quality outcomes data are available, the evidence will be reviewed and considered. Otherwise, this step is skipped.



Rate Quality of Outcome



AUC Development – Steps



AUC Development – Steps

The Strength of Evidence - Evidence Ladder/Hierarchy

- Meta analyses
- High quality systematic reviews
- Large randomized trials – with clear results
- Small randomized trials with uncertain results (i.e., positive trends without statistical significance)
- Nonrandomized trials with contemporary controls
- Nonrandomized trials with historical controls
- Cohort studies
- Case control studies
- Case series
- Expert opinions, Editorials, Ideas

**Strongest
Evidence**



**Weakest
Evidence**



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Appropriate Use Criteria - Issues

**How to determine the topics for AUCs?
Background and Rationale**

SNMMI Prioritization of AUC Topics

- **Prioritize**
 - highest volume Nuclear Medicine Procedures based on the CMS data
- **Conduct an environmental scan**
 - of existing clinical guidelines and AUCs (developed by other organizations)
- **List high volume Nuclear Medicine Procedures lacking appropriate AUCs**
 - (where NM is at a disadvantage and/or the AUCs are not evidence-based)

Highest Volume Nuclear Medicine Studies According to CMS

Modality	Highest Volume Nuclear Exams (CMS)	
<p>Nuclear Medicine (14.08 MM)</p>	Myocardial Ischemia Perfusion (9.97 MM)	
	Bone Scans (2.12 MM)	Prostate Ca
	Breast Ca	
	Back Pain – unspecified	
	Liver/Hepatobiliary (1.17 MM)	
	Respiratory (0.82 MM)	
<p>PET/CT (1.5 MM)</p>	Lung Nodule (malignant neoplasm) – (Solitary pulmonary nodule tops list)	
	Breast Ca	
	ENT related	
	Lymphatic	
	Colon	

Qualified Provider Led-Entities

- CMS proposed a new process for AUC Development
- Organization developing AUC must follow an evidence-based process as specified by CMS, document that process, and apply to CMS to get certified as an “Approved” or “Qualified” Provider-led Entity (Q-PLE). The duration of qualification is 5 years.
- The application to CMS must be made by December 31 – (SNMMI applied December 2015 and was approved June 2016)
- CMS publishes a list of “Approved” or “Qualified” Provider-led Entities by June 30 of the following year
- SNMMI is one of the only 3 specialty societies that was approved as a PLE, along with ACR and ACC
- Instead of reviewing individual AUC, all the documents produced by these “Approved” or “Qualified” provider led entities will be considered “deemed” or “approved”
- CMS has postponed the implementation date for the start of the AUC program to **January 1, 2020** under the MPFS 2018

List of Approved or Qualified-PLEs as of June 2017

• **American College of Cardiology Foundation**

• **American College of Radiology**

• Banner University Medical Group-
Tucson University of Arizona*

• CDI Quality Institute

• Cedars-Sinai Health System*

• Intermountain Healthcare

• Massachusetts General Hospital,
Department of Radiology

• Medical Guidelines Institute*

• Memorial Sloan Kettering Cancer
Center*

• National Comprehensive Cancer
Network

• Sage Evidence-based Medicine &
Practice Institute*

• **Society for Nuclear Medicine and
Molecular Imaging**

• University of California Medical
Campuses

• University of Utah Health*

• University of Washington School of
Medicine

• Virginia Mason Medical Center*

• Weill Cornell Medicine Physicians
Organization

SNMMI AUC Published/Under Development/Topics Identified

SNMMI AUC Published Till Date

- Amyloid Imaging AUC
- Bone Scintigraphy in Breast and Prostate Cancer
- Hepatobiliary Scintigraphy in Abdominal Pain
- Ventilation Perfusion Imaging in Pulmonary Embolism
- PET CT for Restaging and Treatment Response Evaluation in Malignancies
- Somatostatin Imaging for Neuroendocrine Tumors

SNMMI AUC Under Development

- PET Myocardial Perfusion Imaging
- Infection Imaging
- Gastrointestinal Transit
- Prostate Cancer Imaging
- Nuclear Medicine in the Evaluation and Treatment of Differentiated Thyroid Cancer (DTC)

New Topics for AUC

- Lymphoscintigraphy
- Ra-223
- Benign Tumors of Thyroid
- Brain Imaging (HMPAO and DAT)
- Renal Imaging

Collaborating Organizations: AUC Under Development

- American Association of Clinical Endocrinologists (AACE)
- American Academy of Family Physicians (AAFP)
- American College of Cardiology (ACC)
- American College of Nuclear Medicine (ACNM)
- American College of Physicians (ACP)
- American Gastroenterological Society (AGA)
- American Head and Neck Society (AHNS)
- American Society of Clinical Oncology (ASCO)
- American Society of Nuclear Cardiology (ASNC)
- American Society for Radiation Oncology (ASTRO)
- American Thyroid Association (ATA)
- American Urological Association (AUA)
- Canadian Cardiovascular Society (CCS)
- Canadian Nuclear Safety Commission (CNSC)
- Endocrine Society
- European Association of Nuclear Medicine (EANM)

PET-MPI AUC Workgroup Members

Thomas Schindler, MD* (SNMMI)

Robert Gropler, MD (SNMMI)

Timothy Bateman, MD (SNMMI)

Warren Laskey, MD, MPH

Rob Beanlands, MD, FRCPC, FACC (ASNC, ACC, CCS, SNMMI)

Venkatesh Murthy, MD, PhD (SNMMI)

Daniel Berman, MD (ACC, SCCT, SNMMI)

Terrence Ruddy, MD, FRCPC, FACC (CCS, CSNC, SNMMI)

Panithaya Chareonthaitawee, MD (ASNC, SNMMI)

Leslee Shaw, PhD (ACC, SCCT)

Lorraine De Blanche, MD (ACNM)

Prem Soman, MD, PhD, FRCP(UK), FACC (AAC, AANC, SNMMI)

Marcelo Di Carli, MD (SNMMI)

David Winchester, MD (ACP)

Vasken Dilsizian, MD (ASNC, SNMMI)

Hein Verberne, MD, PhD (EANM)

Sharmila Dorbala, MD, MPH (SNMMI)

PET-Myocardial Perfusion Imaging (MPI) AUC Process



Infection Imaging AUC Workgroup Members

Chris Palestro, MD* (SNMMI)

Alicia Clark, MD

Erin Grady, MD, FACNM (ACNM, SNMMI)

Sherif Heiba, MD (SNMMI)

Ora Israel, MD (SNMMI)

Alan Klitzke, MD (ACNM, SNMMI)

Charito Love, MD (ABNM, RSNA, SNMMI)

Mike Sathekge, MD, PhD (SNMMI)

Chun Kim, MD (SNMMI)

Ted Treves, MD (SNMMI)

Tracy Yarbrough, MD, PhD (ACNM, SNMMI)

*Chair

Infection Imaging AUC Process



Gastrointestinal Transit - Workgroup Members

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Thomas Abell, MD (AGA)

Paige Bennett, MD (SNMMI)

Jesus Diaz, MD (ACR, AUR, ARRS, RSNA, SNMMI)

Lucinda Harris, MD (ACP)

William Hasler, MD (AGA)

Andrei Iagaru, MD, FACNM (SNMMI)

Kenneth Koch, MD (AGA)

Richard McCallum, MD (ANMS)

Henry Parkman, MD (ANMS)

Satish Rao, MD (ANMS, AGA)

Mark Tulchinsky, MD, FACNM, CCD (ACNM, SNMMI)

Gastrointestinal Transit AUC Process



Prostate Cancer Imaging AUC Workgroup Members

Hossein Jadvar, MD, PhD, MPH, MBA, FACNM, FSNMMI* (USC; SNMMI)

Leslie Ballas, MD (USC; ASTRO)

Peter Choyke, MD, FACR (NCI; ASCO, SNMMI)

Stefano Fanti, MD (University of Bologna; EANM)

James Gulley, MD, PhD, FACP (NCI; ACP)

Ken Herrmann, MD (Universitätsklinikum Essen; EANM, ENETS)

Thomas Hope, MD (USC; SNMMI)

Alan Klitzke, MD (Roswell Park Cancer Institute; ACNM, SNMMI)

Jorge Oldan, MD (UNC, Chapel Hill; ASCO, SNMMI)

Martin Pomper, MD, PhD (Johns Hopkins Medical School; SNMMI)

Rathan Subramaniam, MD, PhD, MPH, FACNM (UT Southwestern Medical Center; ACNM, SNMMI)

Samir Taneja, MD (NYU Longone Medical Center; AUA)

Hebert Alberto Vargas, MD (Memorial Sloan Kettering Cancer Center; ASCO)

*Chair

Prostate Cancer Imaging AUC Process



Nuclear Medicine in the Evaluation and Treatment of Differentiated Thyroid Cancer AUC Workgroup Members

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Jennifer Aloff, MD, FAAFP (AAFP)

Anca Avram, MD, FACNM (ACNM, SNMMI)

KG Bennet, MD (ACNM, SNMMI)

Erica Cohen, DO, MPH, CCD (ACNM, SNMMI)

Luca Giovanella, MD, PhD (EANM)

Bennett Greenspan, MD, FACNM, FACR (SNMMI)

Seza Gulec, MD

Aamna Hassan, MD

Richard Kloos, MD (ATA)

Carmen Solórzano, MD, FACS (AAES)

Brendan Stack, MD (AHNS)

Mark Tulchinsky, MD, FACNM, CCD (SNMMI)

Michael Tuttle, MD (AACE)

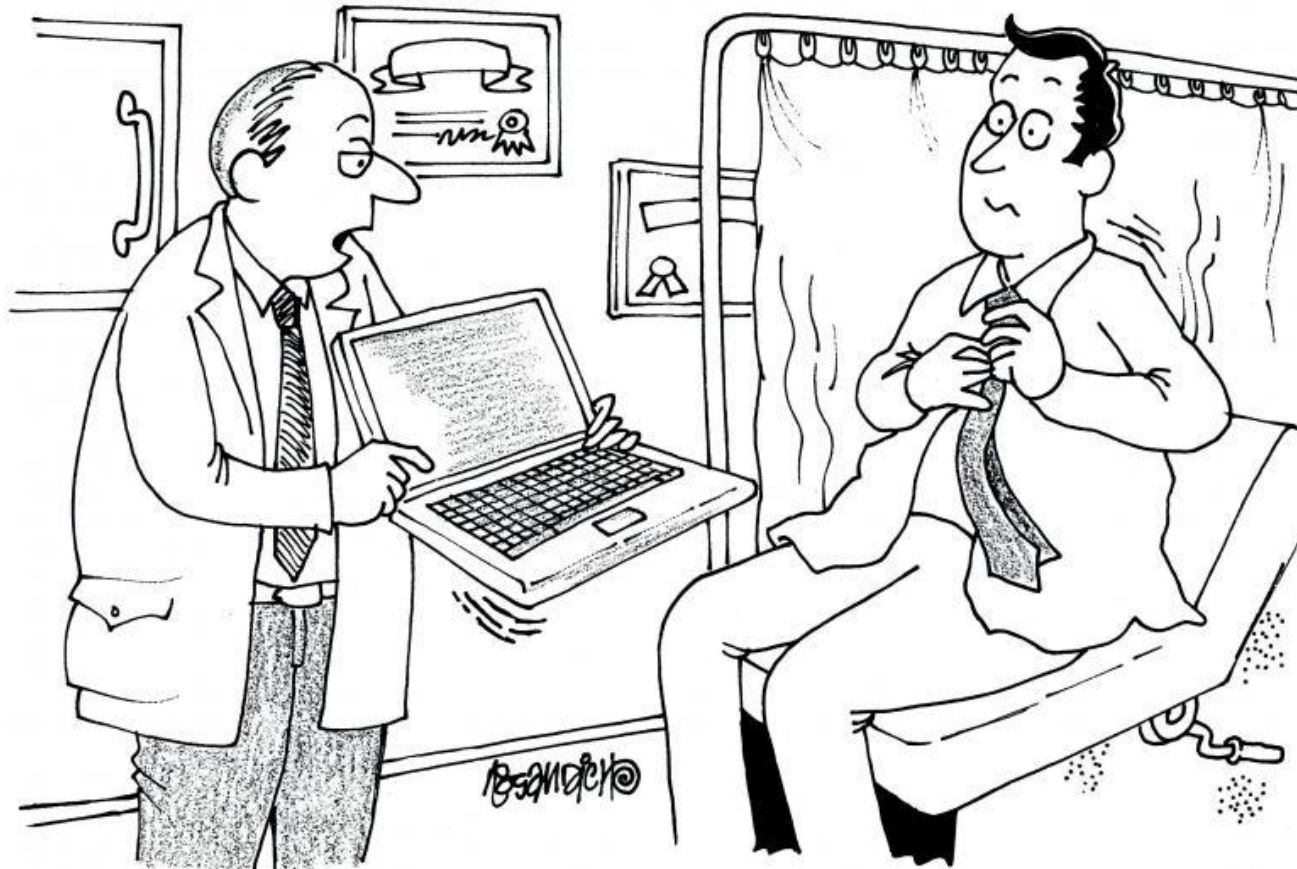
Douglas Van Nostrand, MD, FACP, FACNM (SNMMI)

Jason Wexler, MD (Endocrine Society)

Nuclear Medicine in the Evaluation and Treatment of Differentiated Thyroid Cancer AUC Process



Delivery of AUCs – Clinical Decision Support (CDS) tool(s).



"If you want a second opinion, I'll ask my computer."

Delivery of AUC – Clinical Decision Support (CDS) Mechanism

- “Protecting Access to Medicare Act of 2014” (H.R. 4302)
 - Directs the Secretary of HHS to launch (by 2017) a program that encourages the use of appropriate use criteria for advanced diagnostic imaging services (ADIS)
 - Ordering professionals (OP) will have to **consult AUCs via a clinical decision support mechanism prior to ordering ADIS**, for help in determining whether an exam is clinically appropriate for a patient’s condition
 - In addition to the private sector clinical decision support mechanism, a clinical decision support mechanism to be established by HHS
 - It could be an existing clinical decision support tool of another organization or could be created de novo by HHS
 - CMS/HHS has not stated what this clinical decision support tool would look like or whether CMS will in fact create one in the future

Delivery of AUC – Clinical Decision Support (CDS) Mechanism

- Requirements for the Clinical Decision Support Mechanism
 - The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable AUC
 - The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional
 - In the case where there is more than one applicable AUC for an applicable imaging service, the mechanism indicates the criteria that it uses for the service
 - The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria
 - The mechanism performs other functions such as a requirement to provide aggregate feedback to the ordering professional

Qualified Clinical Decision Support (CDS) Mechanism – November 2017

- AIM Specialty Health ProviderPortal®*
- Applied Pathways CURION™ Platform
- Cranberry Peak ezCDS
- eviCore healthcare's Clinical Decision Support Mechanism
- Medicalis Clinical Decision Support Mechanism
- National Decision Support Company CareSelect™* (Acquired by Change Healthcare in January 2018)
- National Imaging Associates RadMD
- Sage Health Management Solutions Inc. RadWise®
- Test Appropriate CDSM

*Free Tool Available

Clinical Decision Support Mechanisms with Preliminary Qualification - November 2017

- Cerner CDS mechanism
- Evinance Decision Support
- Flying Aces Speed of Care Decision Support
- LogicNets' Decision Engines
- MedCurrent OrderWise™
- Reliant Medical Group CDSM
- Stanson Health's CDSM

Free CDS Mechanism as mandated by PAMA

- Not enough clarity on “Free CDS Mechanism” that will be offered, if at all, by CMS as required by PAMA legislation



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SNMMI Collaboration with CDSMs



stanson  health



medicalis

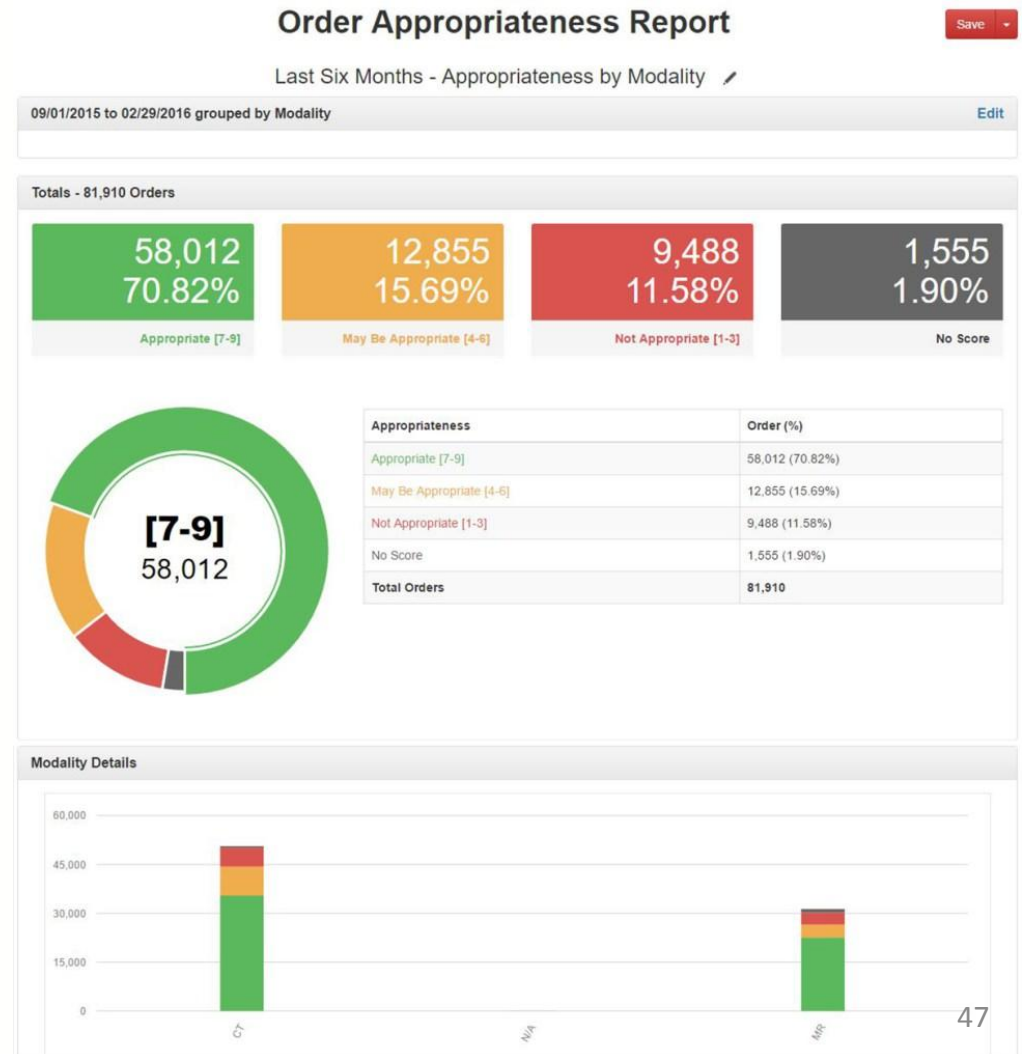
A Siemens Healthineers Company

SNMMI AUC Licensing Agreement with CDSMs

- SNMMI has contracted with **NDSC** and **Stanson Health** to host nuclear medicine AUC developed by the society under a licensing agreement.
- Currently working with these CDSMs to convert AUC recommendations into electronic format and incorporate into the EHRs.
- Exploring collaboration with Medicalis (Siemens Healthineers), Logic Nets and Infinix.

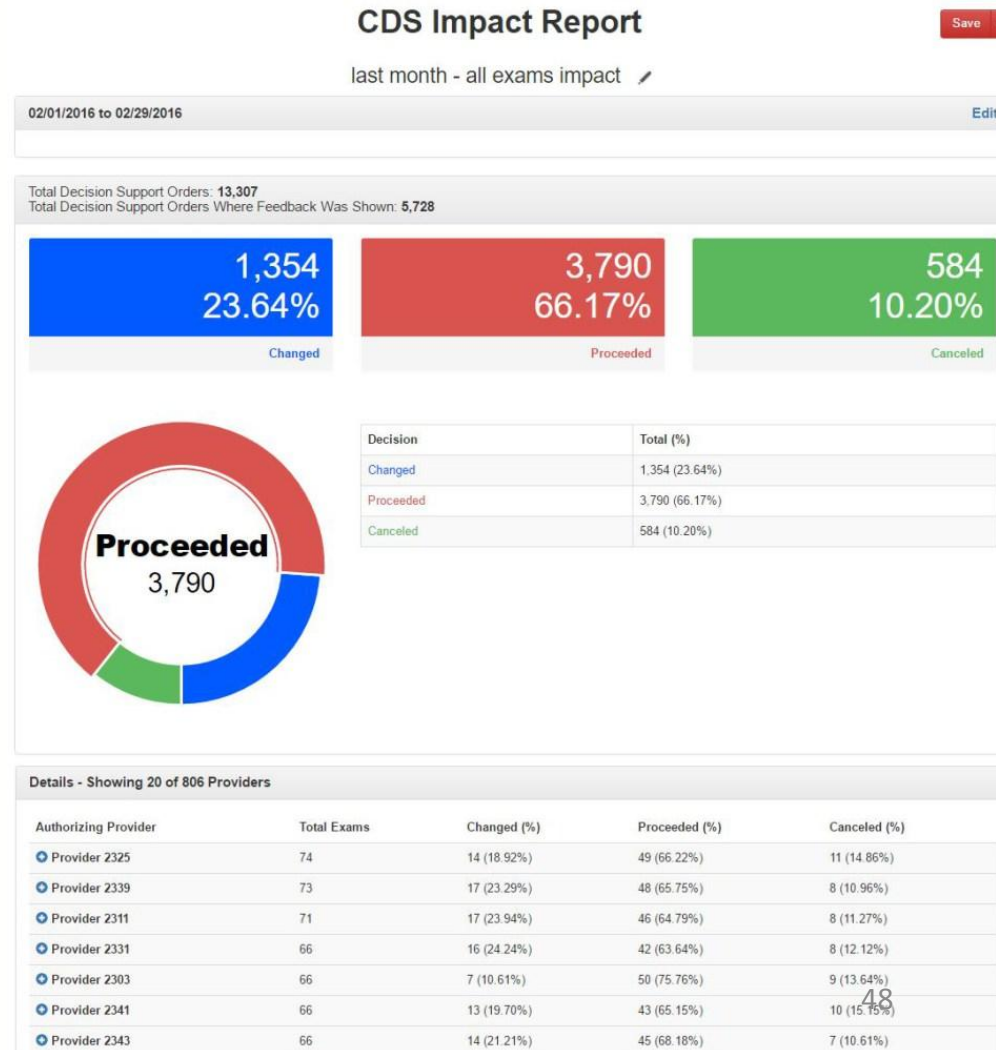
CDSM – Driving Quality Improvement (Source NDSC)

The Order Appropriateness Report provides an overview of an organization’s order scoring breakdown (green, yellow, red, and no score). It includes the percentage and the number of orders that fall into each score range.



CDSM – Driving Quality Improvement (Source NDSC)

The CDS Impact Report shows the total number of orders and the number of times the decision support window was shown to the end user. Within the subset where feedback was shown, the report then shows the percentage of orders where the provider changed to a new exam, cancelled the exam, or proceeded with the original order.




Proceeded
3,790

Details - Showing 20 of 806 Providers

Authorizing Provider	Total Exams	Changed (%)	Proceeded (%)	Canceled (%)
Provider 2325	74	14 (18.92%)	49 (66.22%)	11 (14.86%)
Provider 2339	73	17 (23.29%)	48 (65.75%)	8 (10.96%)
Provider 2311	71	17 (23.94%)	46 (64.79%)	8 (11.27%)
Provider 2331	66	16 (24.24%)	42 (63.64%)	8 (12.12%)
Provider 2303	66	7 (10.61%)	50 (75.76%)	9 (13.64%)
Provider 2341	66	13 (19.70%)	43 (65.15%)	10 (15.15%)
Provider 2343	66	14 (21.21%)	45 (68.18%)	7 (10.61%)

CDSM – Driving Quality Improvement (Source NDSC)

The Red Rate Report shows how a specific provider's ordering scores rank in comparison to the average appropriateness by displaying a provider's normalized deviation from the population, typically within a provider specialty.

Red Rate Report

PDF

Red Rate 

09/01/2015 to 05/01/2016

Details

[Edit Filters](#)

Provider	Odds of Red		Scored Exams	Red Count	Red Rate (unadjusted)	Standard Error
Provider 4636	9.9792		16	5	0.3125	0.5522
Provider 5096	9.4468		13	5	0.3846	0.5602
Provider 5289	9.3764		43	12	0.2791	0.3524
Provider 4951	8.5138		42	11	0.2619	0.3544
Provider 5393	7.8062		23	6	0.2609	0.4832
Provider 4882	7.7033		34	9	0.2647	0.3958
Provider 4593	3.3448		19	3	0.1579	0.6182
Provider 4438	3.3446		12	2	0.1667	0.7576
Provider 5262	3.3329		12	2	0.1667	0.7571
Provider 4181	3.3091		11	2	0.1818	0.7576
Provider 4485	3.1828		24	3	0.125	0.6148
Provider 4578	3.1551		20	3	0.15	0.6126
Provider 4729	3.1307		11	2	0.1818	0.7531
Provider 4643	3.0786		12	3	0.25	0.6262
Provider 5234	2.9764		18	3	0.1667	0.6302
Provider 4517	2.9437		29	3	0.1034	0.6025
Provider 5245	2.9247		11	2	0.1818	0.7449
Provider 4913	2.8218		14	2	0.1429	0.728

Medicare Physicians Fee Schedule Final Rule - 2018

- In response to public comments, CMS is further delaying the effective date for the AUC consultation and reporting requirements to **January 1, 2020**.
- CMS is also finalizing a voluntary reporting period where early adopters can begin to report some consultation information on Medicare claims from July 2018 through December 2019.
- CMS notes that furnishing professionals are required to report the following information on Medicare claims for applicable imaging services:
 - Which qualified CDSM was consulted by the ordering professional
 - Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered
 - The NPI of the ordering professional (if different from the furnishing professional)
- In response to the comments received, CMS decided not to move forward with the G-code approach and will instead further explore and pursue the use of the unique consultation identifier for reporting on Medicare claims.



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MACRA – Quality Payment Program



HERE. TRY THIS

MACRA – Quality Payment Program

- Medicare and CHIP Reauthorization Act (MACRA)
- Signed into law April 2015
- Supports transition from fee-for-service payments to payments based on quality and value
- Established the Quality Payment Program (QPP)

The Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

**The Merit-based Incentive
Payment System (MIPS)**

*If you decide to participate in traditional
Medicare, you may earn a performance-based
payment adjustment through MIPS.*

OR

**Advanced
APMs**

**Advanced Alternate Payment Models
(APMs)**

*If you decide to take part in an Advanced APM, you
may earn a Medicare incentive payment for
participating in an innovative payment model.*

What is Merit-based Incentive Payment System (MIPS)

Combines legacy programs into single, improved reporting program

Physician Quality Reporting System (PQRS)

Value-Based Payment Modifier (VM)

Medicare EHR Incentive Program (EHR)

MIPS

Legacy Program Phase Out

Last Performance Period

2016

PQRS Payment End

2018

What is Merit-based Incentive Payment System (MIPS)

A visualization of how the legacy programs streamline into the MIPS performance categories:



The Quality Payment Program

No change in the types of clinicians eligible to participate in 2018

MIPS eligible clinicians include:



Physicians



Physician Assistants



Nurse Practitioners



Clinical Nurse
Specialists



Certified Registered
Nurse Anesthetists

For 2019 onwards performance years:

Physical and occupational therapists, audiologists, nurse midwives,
clinical social workers, clinical psychologists, and dietitians

The Quality Payment Program

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.

Transition Year 1 (2017) Final



Year 2 (2018) Final



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

MIPS – Non Patient Facing Criteria

No Change in Non-Patient Facing Criteria

Transition Year 1 (2017) Final

- Individual – If you have ≤ 100 patient facing encounters.
- Groups – If your group has $>75\%$ of NPIs billing under your group's TIN during a performance period are labeled as non-patient facing.



Year 2 (2018) Final

- **No Change to Individual and Group policy.**
- **NEW - Virtual Groups** are included in the definition.
 - Virtual Groups that have $>75\%$ of NPIs within a virtual group during a performance period are labeled as non-patient facing

Performance Category Weights

MIPS Performance Categories for Year 2 (2018)



- Comprised of **four** performance categories in 2018.

MIPS Performance Threshold and Payment Adjustment

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	<ul style="list-style-type: none"> Positive adjustment Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	<ul style="list-style-type: none"> Positive adjustment Not eligible for exceptional performance bonus
3 points	<ul style="list-style-type: none"> Neutral payment adjustment
0 points	<ul style="list-style-type: none"> Negative payment adjustment of -4% 0 points = does not participate

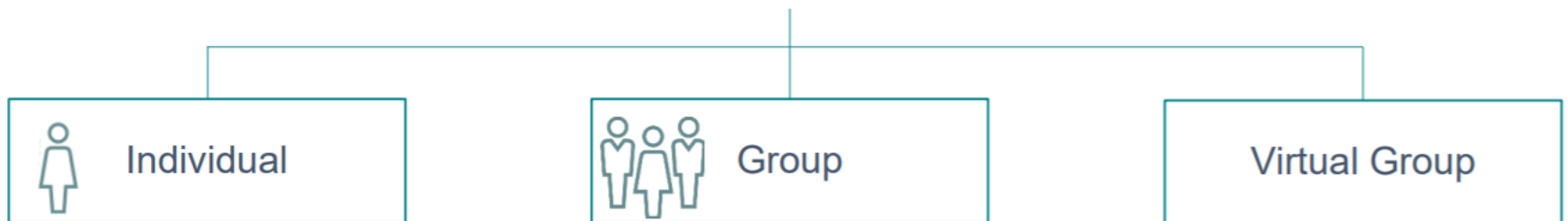


Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	<ul style="list-style-type: none"> Positive adjustment greater than 0% Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	<ul style="list-style-type: none"> Positive adjustment greater than 0% Not eligible for exceptional performance bonus
15 points	Y	<ul style="list-style-type: none"> Neutral payment adjustment
3.76-14.99	Y	<ul style="list-style-type: none"> Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	<ul style="list-style-type: none"> Negative payment adjustment of -5%

Reporting Options

OPTIONS



1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

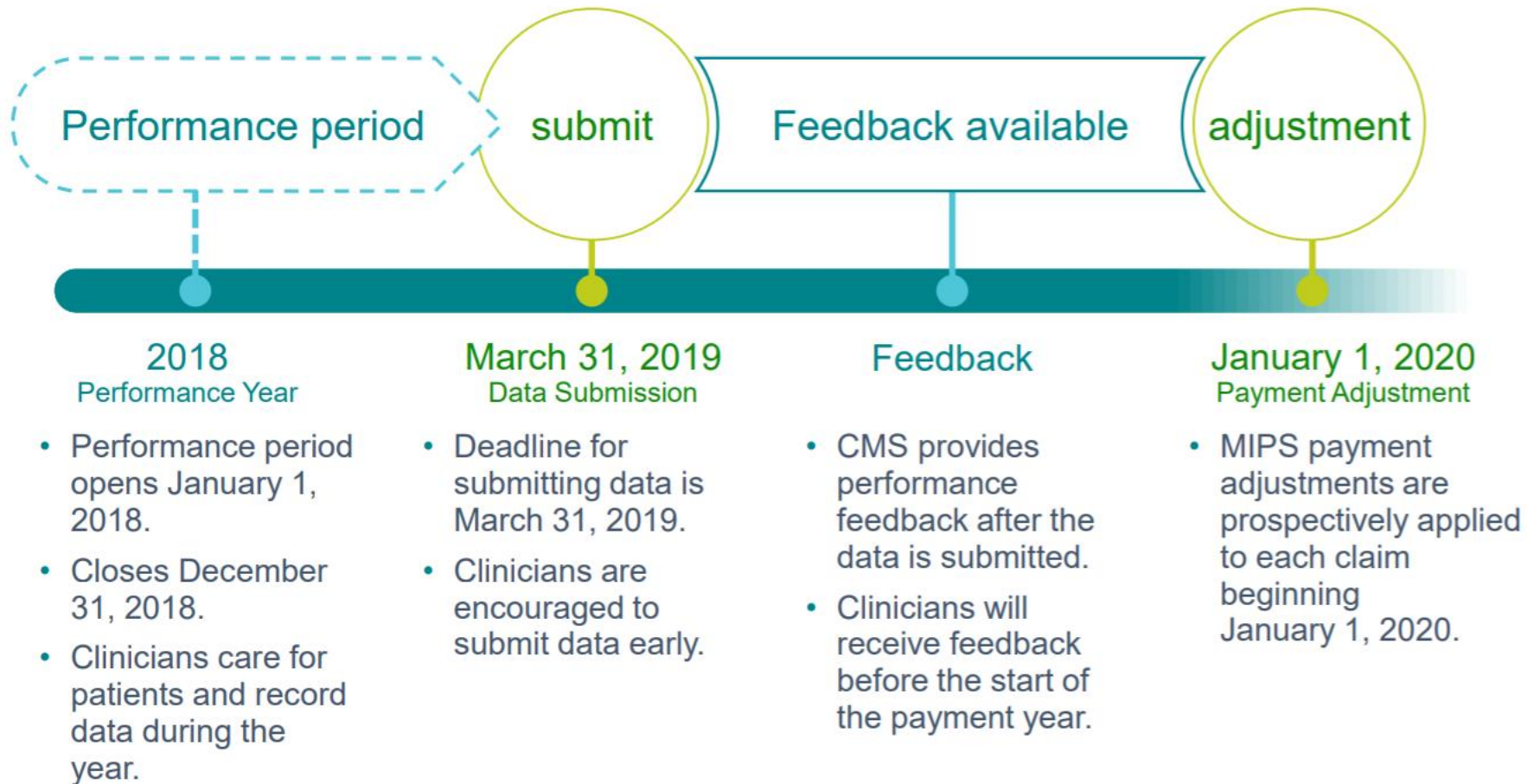
a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* 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.

MIPS Timeline



Updates on AHCA, BCRA and ACA

- H.R.1628 - American Health Care Act of 2017 – Passed the house in May 2017, Senate didn't take it.
- U.S. Senate Committee on Budget released Better Care Reconciliation Act (BCRA) in June 2017 – Did not pass the Senate.
- Impact of Tax Reform Act 2017
 - Elimination of penalties paid by people who fail to have health insurance as required by the so-called individual mandate (could result in 13 million fewer American having health insurance)
 - Potential increases in average premiums as many young, healthy individuals will cease to carry health insurance leaving a sicker, more costly pool behind
 - Increase in the federal deficit by an estimated \$1.45 trillion
 - ACA employer mandate stays in place. Employers with 50 or more full time equivalent employees are required to file ACA information with IRS



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“Known Unknowns” and “Unknown Unknowns”

“Known Unknowns”

- There are “known unknowns” and “unknowns and unknowns” for the future direction of CMS
- Legislative Landscape – Very unlikely that any new healthcare legislation will be taken up before 2018 mid-terms
- Leadership at CMS and HHS – Successful implementation of any program requires sustained buy in from the CMS leadership of successive administrations.
- New leadership at CMS and HHS

“Known Unknowns” – New CMS Administrator



- New CMS Administration – Seema Verma
- CMS non longer operating on the aggressive timeline to tie more Medicare payments to the quality of care received.
- Focus on review of alternative payment methods like “accountable care organization”, “bundled payments” and “primary medical homes”.
- *“... I like to think of our initiative in terms of painting a house. Typically, repainting needs to occur every few years and before you repaint, you need to strip out the layers of paint from underneath... unfortunately, CMS has been applying new layers of paint without taking essential step.”*

– Seema Verma

“Known Unknowns” – New HHS Secretary



- New HHS Secretary Alex Azar.
- Past President of Lilly USA, LLC, the largest division of Eli Lilly and Company.
- More interested in Medicare innovations than his predecessor Tom Price, who famously opposed the idea of requiring physicians to participate in any pilot programs.
- *“... I totally agree about the need for value-based transformation. I think it’s a bipartisan issue that we can improve quality, decrease cost and make our programs more sustainable.” - Alex Azar*

“Unknown Unknowns”

NOW WHEN POLISHED THIS MAY TURN OUT
TO BE A GEM OF SOME SIGNIFICANCE...
OR IT MAY JUST BE A ROCK.
WHAT'S EXCITING, I THINK, IS NOT KNOWING.
SO WHAT DO YOU SAY BABY?



- New Legislations?
- New Regulations?
- New Executive orders?
- More Personnel Changes?
- Something Totally Unexpected?

**"If you don't know
where you are going...
any road will take you
there"**

Lewis Carroll



Thank you!
Questions and Comments?

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