Federal Update

Issues Impacting A/I Specialists and Their Patients

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Hart Health Strategies, Inc.

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Agenda

- MACRA & Allergy/Immunology
  - MIPS
    - Year 1 and Year 2 Proposals
  - APMs
- Current Regulatory Issues
  - 2018 MPFS
  - "Medicare Flexibilities"
  - Network Adequacy
- Regulatory Pipeline

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MACRA & Allergy/Immunology

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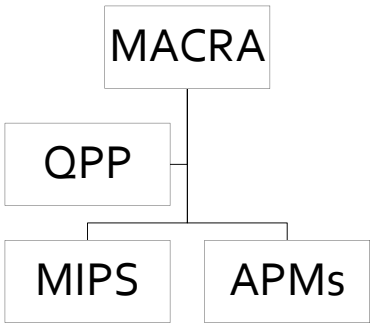
MACRA

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Enacted into law on April 16, 2015
  - **Repealed the flawed Sustainable Growth Rate (SGR) formula!**
  - Established a two-track Medicare physician payment system
    - Merit-Based Incentive Payment System (MIPS)
    - Alternative Payment Models (APMs)
  - Framework for these two programs is known as the "Quality Payment Program"



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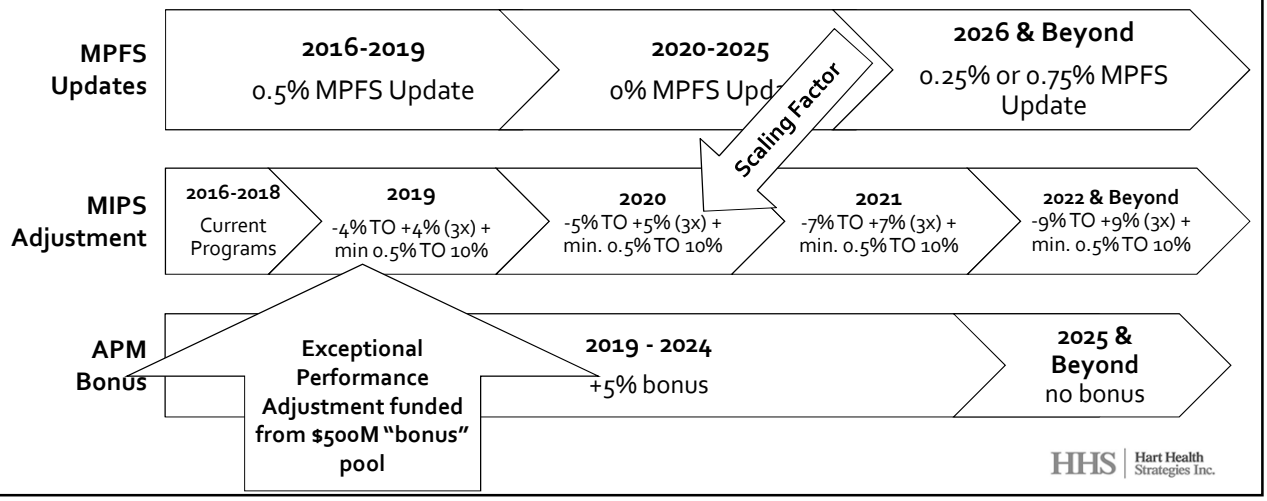
MACRA Payment Adjustments



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MIPS Adjustment & Part B Drugs

- *From the MACRA statute:*
  - *"Application of MIPS adjustment factors.--In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part…"*
- *Clarification in the 2018 QPP Proposed Rule:*
  - *"…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…"*

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MIPS Year 1: Performance Categories and Weights

Quality (60%)

Improvement Activities (15%)

Advancing Care Information (25%)

Cost (0%)

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MIPS Year 1 Snapshot




MIPS Year 1

Sn

Quality (60%; 60 pts)

- Report 6 quality measures, including one outcome/high priority measure, for a minimum of 90 days (or a specialty measure set)
- Bonus points for reporting high priority measures
- 3-point floor for all submitted quality measures
- CMS will only count the "top 6" reported measures toward quality score

Improvement Activities (15%; 40 pts)

- Attest that you completed up to 4 improvement activities for a minimum of 90 *continuous* days*
- Activities are weighted "high" (20 pts) and "medium" (10 pts)
- CMS doubled the points for small practices*
- If at least one clinician in the group performs the activity, the entire group may count it

** 15 or fewer and solo's*

Advancing Care Information (ACI) (25%; 155 pts/ capped @ 100 pts)

- Fulfill **required** measures for a minimum of 90 *consecutive* days (BASE score @ 50%)
- Submit up to 9 measures for additional credit (PERFORMANCE score @ 90%)
- Bonus points available (BONUS @ 5%)

Cost (0%; 0 pts)

- Calculated from claims data; no additional submissions required

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MIPS Year 1 Eligible Clinicians & Exclusions

Who's In

- MIPS Eligible Clinicians defined as:
  - Physicians (as defined in section 1861(r) of the Act)
  - Physician Assistants (PAs)
  - Nurse Practitioners (NPs)
  - Clinical Nurse Specialists (CNSs)
  - Certified Registered Nurse Anesthetists (CRNAs)
- CMS will consider expanding the definition of a MIPS eligible clinician to include additional eligible clinicians starting in year 3

Who's Out

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until the following performance period)
- Below the low-volume threshold
  - Medicare Part B allowed charges < or = $30K or see < 100 Medicare Part B patients a year
- Sufficiently participating in Advanced APMs
  - Qualifying Participants (QP) and Partial QPs

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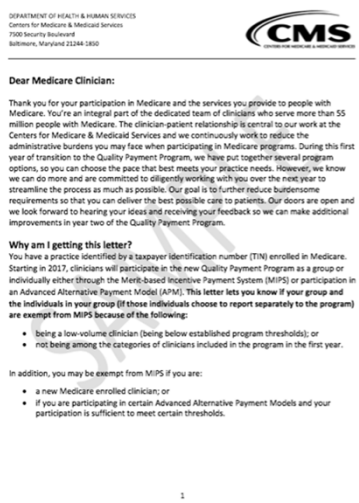
MIPS Year 1 Participation Letter



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS

Dear Medicare Clinician:

Thank you for your participation in Medicare and the services you provide to people with Medicare. You're an integral part of the dedicated team of clinicians who serve more than 55 million people with Medicare. The clinician-patient relationship is central to our work at the Centers for Medicare & Medicaid Services and we continuously work to reduce the administrative burdens you may face when participating in Medicare programs. During this first year of transition to the Quality Payment Program, we have put together several program options, so you can choose the pace that best meets your practice needs. However, we know we can do more and are committed to diligently working with you over the next year to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Our doors are open and we look forward to hearing your ideas and receiving your feedback so we can make additional improvements in year two of the Quality Payment Program.

Why am I getting this letter?
You have a practice identified by a taxpayer identification number (TIN) enrolled in Medicare. Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System (MIPS) or participation in an Advanced Alternative Payment Model (APM). **This letter lets you know if your group and the individuals in your group (if those individuals choose to report separately to the program) are exempt from MIPS because of the following:**

- being a low-volume clinician (being below established program thresholds); or
- not being among the categories of clinicians included in the program in the first year.

In addition, you may be exempt from MIPS if you are:

- a new Medicare enrolled clinician; or
- if you are participating in certain Advanced Alternative Payment Models and your participation is sufficient to meet certain thresholds.

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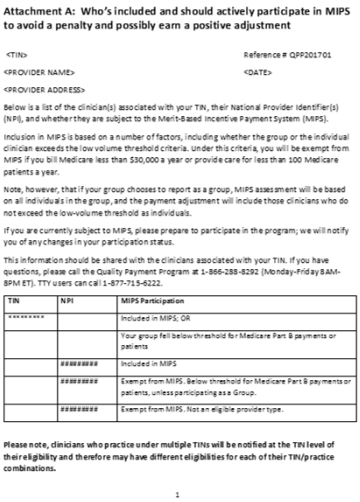

Attachment A: Who's included and should actively participate in MIPS to avoid a penalty and possibly earn a positive adjustment

<TIN> Reference # QPP201701

<PROVIDER NAME> <DATE>

<PROVIDER ADDRESS>

Below is a list of the clinician(s) associated with your TIN, their National Provider Identifier(s) (NPI), and whether they are subject to the Merit-Based Incentive Payment System (MIPS).

Inclusion in MIPS is based on a number of factors, including whether the group or the individual clinician exceeds the low volume threshold criteria. Under this criteria, you will be exempt from MIPS if you bill Medicare less than $30,000 a year or provide care for less than 100 Medicare patients a year.

Note, however, that if your group chooses to report as a group, MIPS assessment will be based on all individuals in the group, and the payment adjustment will include those clinicians who do not exceed the low-volume threshold as individuals.

If you are currently subject to MIPS, please prepare to participate in the program; we will notify you of any changes in your participation status.

This information should be shared with the clinicians associated with your TIN. If you have questions, please call the Quality Payment Program at 1-866-288-8292 (Monday-Friday 8AM-8PM ET). TTY users can call 1-877-715-6222.

TIN	NPI	MIPS Participation
********		Included in MIPS; OR
		Your group fell below threshold for Medicare Part B payments or patients
	########	Included in MIPS
	########	Exempt from MIPS. Below threshold for Medicare Part B payments or patients, unless participating as a Group.
	########	Exempt from MIPS. Not an eligible provider type.

Please note, clinicians who practice under multiple TINs will be notified at the TIN level of their eligibility and therefore may have different eligibilities for each of their TIN/practice combinations.

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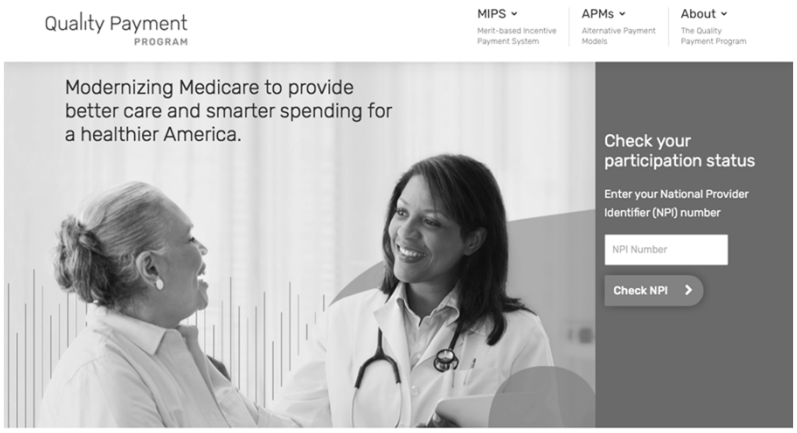
MIPS Participation "Look-up" Tool

qpp.cms.gov



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MIPS Participation & A/I Physicians

- While more than half of clinicians – approximately 738,000 to 780,000 – billing under the Medicare PFS will be excluded from MIPS, **most A/I physicians will be subject to MIPS**

Specialty	Newly-Enrolled	QP Status	Low-Volume	Total Exclusions	Total Inclusions
Allergy/ Immunology (3,994)	166 (4.2%)	38 (1.0 %)	1,284 (32.1%)	1,487 (37.2%)	**2,507 (62.8%)**

Source: CMS MIPS/APMs Final Rule Table 58: MIPS EXCLUSIONS BY REASON AND SPECIALTY FOR MIPS TRANSITION YEAR

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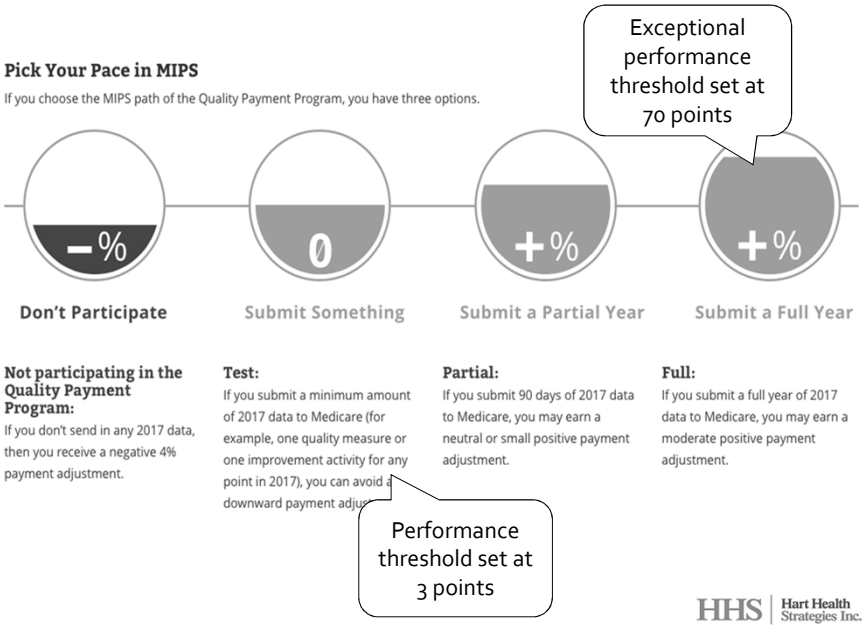
MIPS Year 1 Transition Policies



Source: CMS QPP Web site

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MIPS Year 1 Reporting Mechanisms

	Claims*	Qualified Registry	Qualified Clinical Data Registry (QCDR)	Certified EHR Technology	CMS Web-based Attestation
Quality	✓	✓	✓	✓	
Improvement Activities		✓	✓	✓	✓
Advancing Care Information		✓	✓	✓	✓
Cost	Administrative claims (no submission required)				

** Claims-based reporting is only available for MIPS EC's reporting as individuals*

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MIPS Year 1 Quality *Data Completeness Threshold*

	Claims*	Qualified Registry	Qualified Clinical Data Registry (QCDR)	Certified EHR Technology
Quality	50% of Medicare Part B patients	50% of ALL patients	50% of ALL patients	50% of ALL patients

** Claims-based reporting is only available for MIPS EC's reporting as individuals*

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Allergy/Immunology Specialty Measure Set

Measure #	Measure Title	Claims	Registry/ QCDR	CEHRT
110	Preventive Care and Screening: Influenza Immunization	✓	✓	✓
111	Pneumococcal Vaccination Status for Older Adults	✓	✓	✓
130	Documentation of Current Medications in the Medical Record **(HIGH PRIORITY)**	✓	✓	✓
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis			✓
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	✓	✓	✓
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	✓	✓	✓
331	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse) **(HIGH PRIORITY)**		✓	
332	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) **(HIGH PRIORITY)**		✓	
333	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) **(HIGH PRIORITY)**		✓	
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) **(HIGH PRIORITY)**		✓	
374	Closing the Referral Loop: Receipt of Specialist Report **(HIGH PRIORITY)**			✓
398	Optimal Asthma Control **(HIGH PRIORITY)**		✓	
402	Tobacco Use and Help with quitting Among Adolescents		✓	
444	Medication Management for People with Asthma **(HIGH PRIORITY)**		✓	

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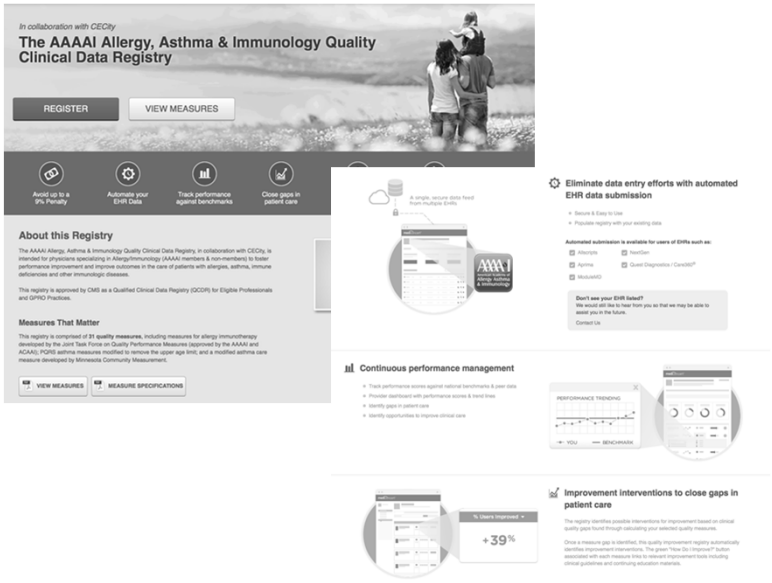
MIPS: Quality
AAAAI's Qualified Clinical Data Registry (QCDR)



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MIPS: Quality
AAAAI's Qualified Clinical Data Registry (QCDR)

CUSTOM SPECIALTY MEASURES

AAAAI 10 - Documentation of the Consent Process for Subcutaneous Allergen Immunotherapy in the Medical Record
Percentage of patients aged 5 years and older initiating subcutaneous allergen immunotherapy injections documented to have received education (or their primary caregiver) about possible adverse reactions.
National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes
Available Submission Options: Registry & eCQM
Type: Process Measure

AAAAI 11 - Asthma Assessment and Classification
Percentage of patients aged 5 years and older with asthma and documentation of an asthma assessment and classification.
National Quality Strategy Domain: Effective Clinical Care
Type: Process Measure

AAAAI 12 - Lung Function/Spirometry Evaluation
Percentage of patients aged 5 years and older with asthma and documentat
National Quality Strategy Domain: Effective Clinical Care
Type: Process Measure

AAAAI 14 - Patient Self-Management and Action Plan
Percentage of patients aged 5 years and older with asthma and documentat
National Quality Strategy Domain: Person and Caregiver-Centered Experience and Out
Type: Process Measure

AAAAI 17 - Asthma Control: Minimal Important Difference Improve
Percentage of patients aged 12 years and older whose asthma is not well-co
Control Questionnaire, or Asthma Therapy Assessment Questionnaire and wi
improvement upon a subsequent office visit during the 12-month reporting p
National Quality Strategy Domain: Person and Caregiver-Centered Experience and Out
Type: Outcome Measure

AAAAI 18 - Penicillin Allergy: Appropriate Removal or Confirmatio
Percentage of patients, regardless of age, with a primary diagnosis of penicil
skin testing or antibiotic challenge that resulted in the removal of the penicill
record if negative or confirmation of the penicillin or ampicillin/amoxicillin all
National Quality Strategy Domain: Communication and Care Coordination
Type: Outcome Measure

CUSTOM SPECIALTY MEASURES

AAAAI 2 - Asthma: Assessment of Asthma Control – Ambulatory Care Setting
Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated at least once during the measurement period for asthma control (comprising asthma impairment and asthma risk).
National Quality Strategy Domain: Effective Clinical Care
Type: Process Measure

AAAAI 5 - Allergen Immunotherapy Treatment: Allergen Specific Immunoglobulin E (IgE) Sensitivity Assessed and Documented Prior to Treatment
Percentage of patients aged 5 years and older who were assessed for IgE sensitivity to allergens prior to initiating allergen immunotherapy AND results documented in the medical record.
National Quality Strategy Domain: Patient Safety
Available Submission Options: Registry & eCQM
Type: Process Measure

AAAAI 6 - Documentation of Clinical Response to Allergen Immunotherapy within One Year
Percentage of patients aged 5 years and older who were evaluated for clinical improvement and efficacy within one year after initiating allergen immunotherapy AND assessment documented in the medical record.
National Quality Strategy Domain: Communication and Care Coordination
Type: Process Measure

AAAAI 7 - Documented Rationale to Support Long-Term Aeroallergen Immunotherapy Beyond Five Years, as Indicated
Percentage of patients aged 5 years and older who were assessed for clinical rationale prior to continuation of aeroallergen immunotherapy beyond 5 years AND rationale documented in the medical record.
National Quality Strategy Domain: Efficiency and Cost Reduction
Available Submission Options: Registry & eCQM
Type: Process Measure

AAAAI 8 - Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated With Allergen Immunotherapy for at Least One Year
Proportion of patients receiving subcutaneous allergen immunotherapy that contains at least one standardized extract (mite, ragweed, grass, and/or cat) who achieved the projected effective dose for all included standardized allergen extract(s) after at least one year of treatment.
National Quality Strategy Domain: Effective Clinical Care
Available Submission Options: Registry & eCQM
Type: Outcome Measure

AAAAI 9 - Assessment of Asthma Symptoms Prior to Administration of Allergen Immunotherapy Injection(s)
Percentage of patients aged 5 years and older with a diagnosis of asthma who are receiving subcutaneous allergen immunotherapy with a documented assessment of asthma symptoms prior to administration of allergen immunotherapy injections.
National Quality Strategy Domain: Patient Safety
Available Submission Options: Registry & eCQM
Type: Process Measure

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Examples of "Improvement Activities"

Expanded Practice Access	**•Expanded hours in evenings and on weekends** **•Provision of same-day or next-day access for urgent care**	Patient Safety and Practice Assessment	•Participation in MOC Part IV for improving professional practice •Use of tools that assist specialty practices in tracking specific measures
Population Management	•Improve health status of communities/work with QIO •Participation in a QCDR or other registries for quality improvement	Achieving Health Equity	**•Seeing new Medicaid patients in a timely manner**
Care Coordination	**•Participation in the CMS Transforming Clinical Practice Initiative**	Emergency Response and Preparedness	•Participation in domestic or international humanitarian volunteer work (registered for 6 months)
Beneficiary Engagement	**•Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan**	Integrated Behavioral and Mental Health	**•Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment**

NOTE: Bolded IA's are high-weighted; unbolded IA's are medium-weighted

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MIPS Year 1 Improvement Activities

Participation in APMs

- MIPS eligible clinicians and groups in a **certified patient-centered medical home** will receive **100 percent (or 40 points)** toward their CPIA score
- MIPS eligible clinicians and groups participating in **APMs*** can earn at least **50 percent (or 20 points)** toward their Improvement Activities score

An eligible clinician that participates in an APM as defined in statute (Sec. 1833(z)(3)(c)), **even one that is not an Advanced APM or MIPS APM, would receive one-half the maximum score for improvement activities through APM participation. CMS defines participation in APMs by presence on a CMS-maintained list associated with an APM.*

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MIPS Year 1 ACI *Base Score (required)*

Option 2: Advancing Care Information Transition Objectives and Measures (Modified Stage 2)

Security Risk Analysis ("yes")	**e-Prescribing** (numerator/ denominator)
Provide Patient Access (numerator/ denominator)	**Health Information Exchange** (numerator/ denominator)

- Fulfill the required measures for a minimum of 90 *consecutive* days to earn your **base credit (50%)**

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MIPS Year 1 ACI *Performance Score*

- For **additional credit (90%),** submit up to 7 measures for a minimum of 90 *consecutive* days

Option 2: Advancing Care Information Transition Objectives and Measures (Modified Stage 2)

REQUIRED: Provide Patient Access	**REQUIRED: Health Information Exchange**
Patient-Specific Education	**View, Download, or Transmit**
Secure Messaging	**Medication Reconciliation**
Immunization Registry Reporting	

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MIPS Year 1 ACI *Bonus Score*

- For **bonus credit (15%),** you can
  - Report Public Health and Clinical Data Registry Reporting measures **(5%)**
  - Attest to completing at least one improvement activity using CEHRT **(10%)**

Option 2: Advancing Care Information Transition Objectives and Measures (Modified Stage 2)

Syndromic Surveillance Reporting

Specialized Registry Reporting

5% BONUS for reporting to AAAAI QCDR

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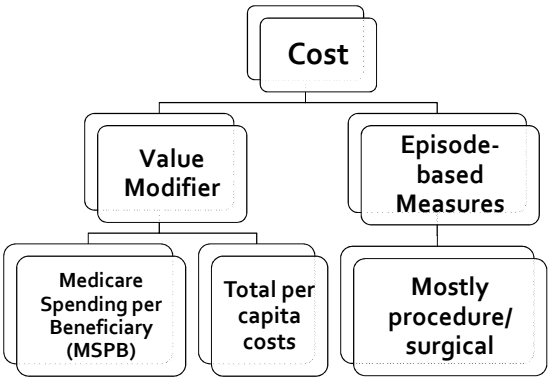
MIPS Year 1 Cost



- Part B drugs (physician-administered) considered in cost measures; **not** Part D drugs
  - Secretary has the authority to include Part D drugs in cost measures, if feasible, in the future
- Risk-adjustment for socio-demographic status (SDS) will be incorporated as feasible, through rulemaking

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MIPS Year 1 Cost

- CMS posted 117 "episode groups" and "trigger codes" for comment, including:
  - Bronchitis and Asthma
  - COPD
  - Respiratory Infections and Inflammations
  - Asthma/COPD
- AAAAI provided robust comments expressing concerns about identified "trigger codes" and other issues

American Academy of Allergy Asthma & Immunology

April 24, 2017

Seema Verma, MPH, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically:
macra-episode-based-cost-measures-info@acumenllc.com

Re: Episode-Based Cost Measure Development for the Quality Payment Program

Dear Administrator Verma,

Established in 1943, the AAAAI is a professional organization with more than 7,000 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases.

We appreciate the opportunity to provide feedback on the draft list of episode groups and trigger codes, as well as your report, *Episode-Based Cost Measure Development for the Quality Payment Program*, to help inform the agency's ongoing efforts in developing cost measures.

Episode-Based Cost Measure Development for the Quality Payment Program

Episode Group Selection

CMS considered Medicare expenditures, clinician coverage, and the opportunity for improvement in acute, chronic, and procedural care settings in selecting the episode groups to be considered for development. Therefore, it is no surprise that several conditions managed by allergy/immunology (A/I) professionals were targeted for episode development, including

- Bronchitis and Asthma,
- Chronic Obstructive Pulmonary Disease (COPD),
- Respiratory Infections and Inflammations, and
- Asthma/COPD.

(more)

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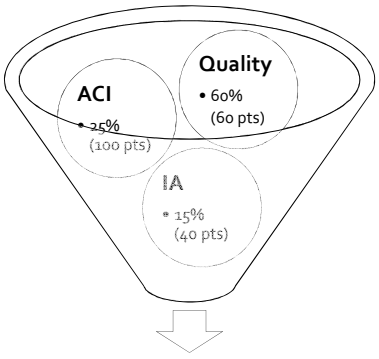
MIPS Year 1 Final Score



Final Score	Payment Adjustment
≥ 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%

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That seems easy, right?

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MIPS Year 2: Proposals

- More clinicians will be exempt from MIPS
  - CMS proposes to increase the low-volume threshold exempt individuals or groups with fewer than $90,000 in Part B charges or 200 Part B patients (up from $30,000 and 100 patients in Year 1)
  - This means 63% of all Medicare clinicians will be exempt from MIPS in 2018
- "Pick your pace" will continue in Year 2 with modifications
  - CMS proposes to maintain the 3-point floor for quality measures (in most instances)
  - CMS proposes to increase the MIPS performance threshold from three to 15
- Cost will continue to be held at 0% of the final score

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MIPS Year 2: Proposals

- Use of 2015 Edition CEHRT is optional in 2018, with the option for bonus points for those who do upgrade their systems
- Small practices may be exempt from MIPS ACI under new "significant hardship" exemptions authorized under 21st Century Cures
- Only 90-days of reporting for the ACI performance category will be required in 2018 and 2019
- Virtual groups will be offered as a new way for practices to participate in MIPS
- Reporting can be accomplished through multiple mechanism with the ACI, quality and improvement activities categories to meet program requirements

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MIPS Year 2 Impact on Allergy/ Immunology Measure Set

- Addition of:
  - Measure #238: Use of High-Risk Medications in the Elderly
  - Measure #338: HIV Viral Load Suppression
  - Measure #340: HIV Medical Visit Frequency
- Removal of:
  - Measure #331: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse) (HIGH PRIORITY) – *Moved to Emergency Medicine/Family Medicine Specialty Measure Sets*
  - Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) (HIGH PRIORITY) – *Moved to Emergency Medicine/Family Medicine Specialty Measure Sets*
  - Measure #333: Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) (HIGH PRIORITY) – *Moved to Emergency Medicine/Family Medicine Specialty Measure Sets*
  - Measure #334: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) (HIGH PRIORITY) – *Moved to Family Medicine Specialty Measure Set*
  - Measure #398: Optimal Asthma Control (HIGH PRIORITY) – *Moved to Family Medicine Specialty Measure Set*
  - Measure #444: Medication Management for People with Asthma (HIGH PRIORITY) – *Moved to Family Medicine Specialty Measure Set*

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MIPS Year 2 Impact on Allergy/ Immunology Specialists

- In 2018, approximately 37 percent of 1,548,022 Medicare clinicians billing to Part B will be included in MIPS, **however, most A/I physicians will be exempt from MIPS**

Number of MIPS eligible clinicians by specialty	% engaging with quality reporting	% w/ + or null payment adj.	% w/ exp. payment adj.	% w/ - payment adj.
A/I physicians (1,692)	89.4%	90.0%	80.5%	10.0%

Source: CMS 2018 QPP Proposed Rule Table 87

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APMs in MACRA

- MACRA defines APMs at section 1833(z)(3)(c) as:
  - CMS Innovation Center Model (under section 1115A, other than a health care innovation award)
  - Medicare Shared Savings Program (section 1899)
  - A demonstration under the Health Care Quality Demonstration Program (section 1866C)
  - A demonstration required by Federal law

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Advanced APMs in MACRA

- To be an Advanced APM, MACRA requires the APM to meet the following three criteria:
  1) Require participants to use **certified EHR technology**;
  2) Provide payment for covered professional services based on **quality measures** comparable to those used in the quality performance category of MIPS; and
  3) Either:
     - be a Medical Home Model expanded under CMS Innovation Center authority; or
     - require participating APM Entities to **bear more than a nominal amount of financial risk** for monetary losses.

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Physician-Focused Payment Models (PFPMs)

- An APM:

1. in which **Medicare is a payer**;
2. in which eligible clinicians that are **EPs** as defined in section 1848(k)(3)(B) of the Act **are participants and play a core role in implementing the APM's payment methodology**, and
3. which **targets the quality and costs of services** that eligible clinicians participating in the Alternative Payment Model provide, order, or can significantly influence

- Does not have to be an Advanced APM

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First PTAC Recommendations

- PTAC deliberated and voted on the first set of models April 10 – 11, 2017

Model	Recommendation
Project Sonar, submitted by Illinois Gastroenterology Group and SonarMD, LLC	Recommend for limited-scope testing
The COPD and Asthma Monitoring Project (CAMP), submitted by Pulmonary Medicine, Infectious Disease and Critical Care Consultants Medical Group, Inc.	Do not recommend
The American College of Surgeons – Brandeis Advanced Alternative Payment Model, submitted by the American College of Surgeons	Recommend for limited scope testing

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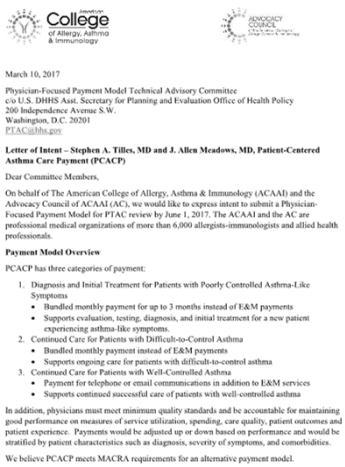
2

Pending LOI: *Patient-Centered Asthma Care Payment*



March 10, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Letter of Intent – Stephen A. Tilles, MD and J. Allen Meadows, MD, Patient-Centered Asthma Care Payment (PCACP)

Dear Committee Members,

On behalf of The American College of Allergy, Asthma & Immunology (ACAAI) and the Advocacy Council of ACAAI (AC), we would like to express intent to submit a Physician-Focused Payment Model for PTAC review by June 1, 2017. The ACAAI and the AC are professional medical organizations of more than 6,000 allergists-immunologists and allied health professionals.

Payment Model Overview

PCACP has three categories of payment:

1. Diagnosis and Initial Treatment for Patients with Poorly Controlled Asthma-Like Symptoms
   - Bundled monthly payment for up to 3 months instead of E&M payments
   - Supports evaluation, testing, diagnosis, and initial treatment for a new patient experiencing asthma-like symptoms.
2. Continued Care for Patients with Difficult-to-Control Asthma
   - Bundled monthly payment instead of E&M payments
   - Supports ongoing care for patients with difficult-to-control asthma
3. Continued Care for Patients with Well-Controlled Asthma
   - Payment for telephone or email communications in addition to E&M services
   - Supports continued successful care of patients with well-controlled asthma

In addition, physicians must meet minimum quality standards and be accountable for maintaining good performance on measures of service utilization, spending, care quality, patient outcomes and patient experience. Payments would be adjusted up or down based on performance and would be stratified by patient characteristics such as diagnosis, severity of symptoms, and comorbidities.

We believe PCACP meets MACRA requirements for an alternative payment model.

- "To improve outcomes for asthma patients and control costs for payers"
- "To resolve current payment barriers to providing optimum asthma care"

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Slide 36

2 Replaced with another slide, so not likely to use this one, but saving this one just in case
Cindy Moon, 4/14/2017

Other Regulatory Issues & Regulatory Pipeline

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2018 MPFS Proposals

Proposed 2018 Conversion Factor	**$35.99 (up 0.10)**
Impact of RVU changes on A/I	**-3%**

- Misvalued Code Initiative
  - 95004, Perc. Allergy Skin Tests – No change in work RVU; Proposed changes in direct PE inputs
- E/M Guidelines
  - Seeking comments to update the guidelines
- PQRS Reporting
  - Reduce the number of required measures to 6 from 9
- Value Modifier
  - If you didn't meet the quality reporting requirement:
    - Reduce the penalty for 2018 to -2 instead of -4 for groups of 10+
    - Reduce the penalty for 2018 to -1 instead of -2 for solo practitioners and groups of 2-9
  - If you met the quality reporting requirement, hold harmless from the penalty
  - Reduced maximum upward adjustment:
    - From 4x to 2x for high quality/low cost
    - From 2x to 1x for average quality/ low cost or high quality average cost
- Implementation of MACRA Patient Relationship Codes

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"Medicare Flexibilities" Request for Information

- CMS has released a "Request for Information" welcoming feedback on the Medicare Program as part of each payment regulation issued this year, including the 2018 MPFS
- "*…committed to maintaining flexibility and efficiency throughout the Medicare program…*"
- "*…start a national conversation about improving the health care delivery system and about how Medicare can contribute to making the delivery system less bureaucratic and complex, and how we can reduce burden for clinicians, providers and patients in a way that increases quality of care and decreases costs – and thereby making the health care system more effective, simple and accessible while maintaining program integrity and preventing fraud…*"
- "*…soliciting ideas for regulatory, sub-regulatory, policy, practice and procedural changes to better accomplish these goals. Ideas could include recommendations regarding payment system re-design, elimination or streamlining of reporting, monitoring and documentation requirements, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, supporting doctor-patient relationship in care delivery, and facilitating patient-centered care. They could also include recommendations regarding when and how CMS issues regulations and policies, and how CMS can simplify rules and policies for Medicare beneficiaries, clinicians, providers and suppliers…*"
- "*…CMS should be provided with clear and concise proposals that include data and specific examples. If the proposals involve novel legal questions, analysis regarding CMS' authority is welcome…*"

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Network Adequacy

- ACA Market Stabilization final rule released by the Centers for Medicare & Medicaid Services (CMS) on April 13, 2017
- Finalizes proposals to defer development and enforcement of network adequacy standards to States and private accrediting organizations
  - State regulators would conduct network adequacy reviews where authorized, in lieu of CMS assessing plans based on previously established "time and distance" standards
  - Where States lack authority to conduct reviews, CMS would revert to 2014 plan year standards
    - Plan accreditation by an HHS-recognized accreditation body (i.e., AAAHC, NCQA or URAC)
    - Unaccredited plans would need to demonstrate its network adequacy standards are consistent with the National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act 74 (updated October 2015)

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Network Adequacy

- Significant concerns from the patient and provider community that network adequacy will deteriorate
  - Most states are not prepared to address network adequacy and already faced challenges before the Marketplace was in existence with their Medicaid plans
  - Accrediting organizations have no enforcement capabilities and are not an appropriate surrogate for a regulatory agency
  - Medicare Advantage (MA) plans adopted "narrow networks", which caused access to care issues and prompted the establishment of federal standards
- CMS believes States are best positioned to determine what constitutes an adequate network in their geographic area, but will monitor States' implementation of the NAIC Model Act and use that information to shape future network adequacy policy
- CMS will provide information to issuers about which States have been determined not to have sufficient network adequacy processes in the near future

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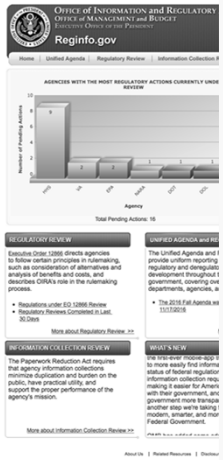
Regulations Pending OMB Review



List of Regulatory Actions Currently Under Review

(Agency: HHS; Rule Stage: Proposed Rule; Length of Review: ALL; Economically Significant: ALL; International Impact: ALL)

Department of Health and Human Services

AGENCY: HHS-CMS | **RIN:** 0938-AT13 | **Status:** Pending Review
TITLE: CY 2018 Updates to the Quality Payment Program (CMS-5522-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 03/22/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AT04 | **Status:** Pending Review
TITLE: CY 2018 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-1674-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 04/05/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AT01 | **Status:** Pending Review
TITLE: CY 2018 Home Health Prospective Payment System Rate Update; Value-Based Purchasing Model; and Quality Reporting Requirements (CMS-1672-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 04/09/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AT03 | **Status:** Pending Review
TITLE: CY 2018 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates (CMS-1678-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 04/12/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AT02 | **Status:** Pending Review
TITLE: CY 2018 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B (CMS-1676-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 04/17/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AS90 | **Status:** Pending Review
TITLE: Medicare Program; Changes to Advancing Care Coordination through Episode Payment Models; Cardiac Rehabilitation Incentive Payment Model; and Comprehensive Care for Joint Replacement Payment Model
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** Yes
RECEIVED DATE: 04/26/2017 | **LEGAL DEADLINE:** Statutory

AGENCY: HHS-CMS | **RIN:** 0938-AT18 | **Status:** Pending Review
TITLE: Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements (CMS-3342-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** No
RECEIVED DATE: 04/26/2017 | **LEGAL DEADLINE:** None

AGENCY: HHS-CMS | **RIN:** 0938-AT19 | **Status:** Pending Review
TITLE: Expedited Coverage of Innovative Technology (ExCITe) (CMS-3344-P)
STAGE: Proposed Rule | **ECONOMICALLY SIGNIFICANT:** No
RECEIVED DATE: 04/26/2017 | **LEGAL DEADLINE:** None

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Regulations Pending OMB Review

- ~~*CY 2018 Revision to Payment Policies Under the Physician Fee Schedule and Other Revision to Medicare Part B*~~
- Medicare Program; Changes to Advancing Care Coordination through Episode Payment Models; Cardiac Rehabilitation Incentive Payment Model; and Comprehensive Care for Joint Replacement Payment Model
- Expedited Coverage of Innovative Technology (ExCITe)
- Coverage Of Certain Preventive Services Under The Affordable Care Act

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Thank you!

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