Currents

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ASDS
American Society for Dermatologic Surgery

COSMETIC AND RECONSTRUCTIVE EXPERTISE
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Hit a home run with MACRA in 2018

MACRA update, including MIPS and advanced APMs

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By Clifford Warren Lober, MD, JD

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) reflects the shift in the Centers for Medicare and Medicaid Services' (CMS) payment policy from volume to value. Despite CMS's intention to decrease the administrative burden, many physicians feel confused, aggravated, and frankly overwhelmed. This is unfortunate, since virtually all dermatologists are already doing what is necessary to not merely avoid a penalty, but rather to get a bonus payment under the Quality Payment Program (QPP). They may simply need to document their efforts.

MACRA in 2018

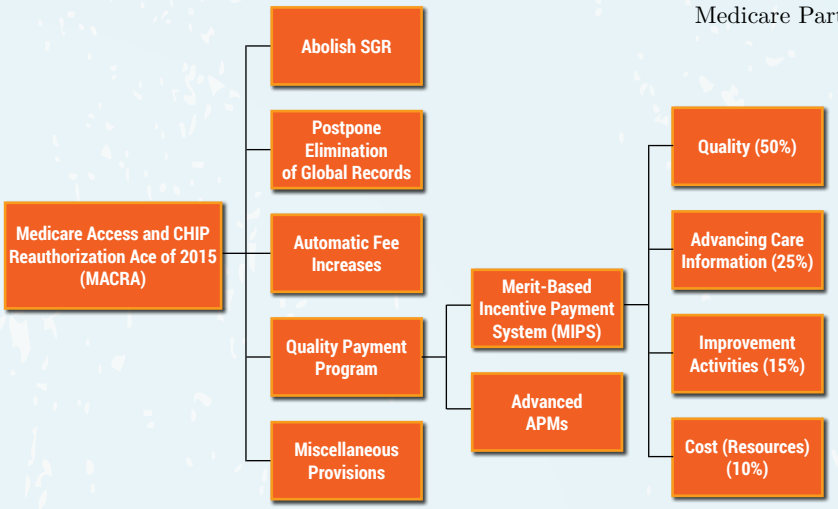
CMS actuaries anticipate that, in performance year 2018:

- 93.1 percent of dermatologists will receive a positive or neutral payment adjustment.
- 66.4 percent will receive a bonus for "exceptional performance" in addition to a positive payment adjustment.
- 90.9 percent of clinicians in small practices (15 or fewer clinicians) will receive a positive or neutral adjustment.
- 61.3 percent will receive a positive adjustment as well as payment for exceptional performance.

MACRA is not part of the Affordable Care Act (ACA, "ObamaCare"). Even if the ACA were abolished, none of the provisions of MACRA would automatically disappear. In addition to the QPP, MACRA has several other mandates that directly affect dermatologists:

Abolishing the SGR By permanently abolishing the sustainable growth rate, MACRA avoided a 23.7 percent decrease in physician fees, which was scheduled to take effect in 2015. Result: We are no longer confronted with this potentially horrendous decrease in our payments every year!

Postponing elimination of global periods MACRA postponed the proposed elimination of global periods, which was scheduled to take effect in 2017 for those procedures with 10-day global periods and this year for procedures with 30-day global periods. The 2017 Physician Fee Schedule required CMS to review, beginning July 1, 2017, billings from physician groups of 10 or more practitioners in nine specified states to determine whether patients who had procedures reported by more than 100 practitioners and billed more than 10,000 times *or* that had annual charges exceeding $10 million annually were being seen during the global periods. Result: Without MACRA, global periods would *already* have been eliminated and would probably have cost every dermatologist literally tens of thousands of dollars.



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Mandating fee increases MACRA mandates a 0.5 percent increase in the Physician Fee Schedule from 2016 through 2019. As a result, the 2017 conversion factor was +0.237 percent, and the 2018 conversion factor is +0.410 percent. Without MACRA, the conversion factor would have been negative both years.

From 2020 through 2025, there are no scheduled increases. There will, however, be annual increases of 0.25 percent for practitioners subject to Merit-based Incentive Payment System (MIPS) and an annual 0.75 percent increase for qualified participants in advanced APMs beginning in 2026. These provisions are not part of the QPP, but rather are a separate mandate of MACRA.

Quality Payment Program The QPP has two components: The Merit-based Incentive Payment System (MIPS) and advanced Alternative Payment Models (advanced APMs). Physicians are subject to MIPS unless they are a qualified providers in an advanced APM or otherwise exempt. Eligible practitioners include not only physicians but also physician assistants, nurse practitioners, and others.

MIPS exemption You are exempt from MIPS if you are in your ***first year of participation in Medicare Part B***, are a ***qualified provider in an advanced APM***, *or* fall within the ***low volume exception*** (having $90,000 or less in Medicare Part B allowed charges *or* seeing 200 or fewer Part B-enrolled beneficiaries). **Partially qualified providers**, discussed below, may elect not to report under MIPS. Practitioners who are exempt may not opt-in during the 2018 performance year. You can easily determine whether you are exempt from MIPS by going to *qpp.cms.gov* and entering your NPI number.

In performance year 2017, approximately 2,341 dermatologists were exempt from MIPS. Of these, 1,671 were exempt due to low volume, 531 were in their first year of Medicare Part B participation, and only 139 were qualified participants in advanced APMs. This is not surprising, since there

were less than a dozen advanced APMs in 2017 and several were either not offered in all states or were available only to certain specialists (e.g., orthopedics or primary care). Furthermore, for performance years 2017 and 2018, to be a **qualified provider** you must either receive 25 percent of your Medicare income *or* see 20 percent of your Medicare patients through an advanced APM.

Virtual groups Practitioners can report as individuals, part of a group, or (new for 2018) as part of a **virtual group**. A virtual group is a combination of one or more solo MIPS-eligible practitioners and one or more groups of 10 or fewer MIPS-eligible clinicians who come together "virtually". A virtual group will be considered a small group if it consists of 15 or fewer eligible clinicians. They can belong to different specialties or practice in separate locations. A formal written agreement is required. Virtual groups, like other groups, cannot report by claim. The option to form a virtual group for performance year 2018 closed on Dec. 31, 2017.

"Pick your pace" Providers who are not exempt from MIPS must choose an option under what CMS euphemistically calls "Pick Your Pace". There are five options:

1. Doing nothing: If you decide not to participate in performance year 2018, you will incur a five percent penalty for all of your Medicare Part B payments in 2020. This penalty will increase to seven percent in performance year 2019 and to nine percent in 2020. Doing nothing and accepting the penalty is absolutely the worst possible choice!

2. Test the QPP: This option is useful if your goal is only to avoid being penalized. You "Test the QPP" by submitting just enough information in 2018 to avoid the penalty threshold by attaining a composite payment score (CPS) of 15 or greater. Your CPS is a number between zero and 100 which is determined by your performance on quality measures (50 percent), advancing care information (25 percent), improvement activities (15 percent), and cost (10 percent).

Your CPS in performance year 2018 will determine whether you will receive a bonus, penalty, or no adjustment to your Medicare payments in 2020. If you are in a small practice (15 or fewer eligible clinicians) in payment year 2018 and you submit *any* data you will *automatically* get five bonus points added to your CPS. Therefore, if you submit data on only one patient for each of **four** quality measures you will receive (four measures X three points per measure) 12 points for these measures as well as the five bonus points, or a total of 17 for your CPS. *Penalty avoided!* Alternatively, a practitioner in a small practice can report a single high-value improvement activity and get 15 for his/her CPS. Again, *penalty avoided!*

3. Participate for full year: In order to receive more than three points for each quality measure you report, you need (among other requirements) to meet the minimum case volume requirement of 20 patients per measure. By reporting quality measures for the full year, it is more likely you will be able to reach the required case volumes.

4. Participate for part of the year: In 2018, you may submit data for advancing care information and improvement activities for a 90-day period, just as you could in 2017. Quality and cost measures, however, will be evaluated for the entire 12-month period.

5. Qualified practitioner in an advanced APM: Qualified practitioners in advanced APMs are exempt from MIPS and receive a five percent bonus in addition to any incentives built into the APMs. However, for reasons cited above, only 139 dermatologists nationwide were qualified practitioners in advanced APMs in 2017.

Composite performance score Whether you receive a bonus, penalty or no adjustment to your Medicare payment will be determined by your composite performance score. This is a number from zero to 100 that is determined by your performance in four categories. Although you can use different submission mechanisms (claims, registry, etc.) for different performance categories (quality, advancing care information, or improvement activities), you must use the same mechanism when submitting data within a single performance category.

1. Quality: This performance category replaces PQRS and the quality component of the value-based modifier. It counts of **50 percent** of the composite score. Next year and thereafter, it will be worth 30 percent.

2. Advancing Care Information: Replacing "meaningful use," this performance category counts for **25 percent** of your composite score.

3. Improvement Activities: Of all the performance categories, it is the easiest in which to score points since you are almost certainly already doing some or many of these activities. It counts for **15 percent**.

4. Cost: This category replaces the cost component of the value-based modifier and counts for **10 percent** of your composite score. In the 2019 performance year and thereafter, cost will count for 30 percent. Unlike the other performance categories, CMS will calculate cost for you and you do *not* have to submit any information on cost.

5. Bonuses: **Small practices** (having 15 or fewer providers) will automatically get **five points** added to their composite performance score if they submit *any* data. Up to **five points** will be added if you are seeing **complex patients** as determined by their Hierarchical Conditions Category score and whether they are duel eligible for Medicare and Medicaid. The latter is viewed by CMS as a proxy for "social risk."

6. Exceptional Performance: Practitioners with a composite performance score of **70 or greater** will also earn a bonus payment of up to 10 percent for "exceptional performance."

Extreme and uncontrollable circumstances CMS defines these circumstances as "rare" and "entirely outside the control of the clinician." The example given in the final rule is "a tornado or fire destroying the only facility in which a clinician practices." Under these circumstances, CMS will reweigh any or all of the performance categories, allocating the percentages to the remaining categories. If CMS does not have data on at least two performance categories, they will make the composite performance score equal to the performance threshold so that no penalty will be assessed. An application for a hardship exception is required and must be submitted by Dec. 31, 2018.

Measure specification and data validation requirements
Be sure to review the **measure specification** and **data validation** (documentation) requirements for all performance measures you report. Several of the quality, advancing care information, and improvement activity measures have had changes in their performance and/or documentation requirements since 2017.

Quality You must report six quality measures, one of which must be an outcome measure. If there are no applicable outcome measures, one other high priority measure must be reported. Each measure is worth up to 10 points. Alternatively, you may select six measures from the dermatology specialty set selected by CMS. In either case, you may report less than six measures if fewer are applicable to your practice. CMS defines applicable to mean "measures relevant to a particular MIPS eligible clinician's services or care rendered." If you are in a group of 16 or more providers, CMS will calculate a seventh measure ("all-cause hospital readmission rate") if you meet the minimum case volume requirement of 200 cases.

When reporting quality measures, you must meet the case volume and data completeness requirements in order to get more than three points for any measure. **Case volume** requires that you report a minimum of 20 cases for *all* quality measures (except for the "all-cause hospital readmission" measure mentioned above). In performance year 2018, quality measures must be reported for a full year, *not* 90 days. Your performance on each quality measure will be **benchmarked** against that of other practitioners reporting the same measure. Depending upon the decile of your relative performance, you will between three and 10 points for each measure that meets the case volume and data completeness requirements. The **data completeness** requirement means that you must report on 60 percent of your Medicare Part B patients when reporting by claim or 60 percent of all of your patients (*yes*, including non-Medicare patients) when reporting by data registry or EHR.

If you do not meet the case minimum or data completeness requirements, or if the measure does not have a benchmark, you will only receive three points for that measure. The only exception is practices with 16 or more providers which do not meet the data completeness requirement. They will only receive one point for each such measure.

You will receive a **bonus** of up to 10 percent when you report outcome measures (above the required one, two points each), patient experience measures (two points each), or high priority measures (one point each). You will also receive up to 10 percent for using certified health electronic health record technology (one point per measure). You can only receive, however, up a 10 percent bonus between these two methods. However, you can earn up to a separate, additional 10 percent bonus based upon the rate of your improvement in this category when compared to that of performance year 2017 if you participated last year. Therefore, you may earn a total of up to 20 percent in bonus points!

All of the quality measures are available at *qpp.cms.gov*. After accessing this website, click on "MIPS" on top if the opening page and select "Quality Measures" on the drop-down menu. You will see a deep blue banner that allows you to select "Search by Keyword," "Filter by: High Priority Measure, Data Submission Method," and / or "Specialty Measure Set." You can use these helpful filters or, alternatively, see all available quality measures listed alphabetically below where you can easily scroll through them in a matter of minutes. After selecting a measure, click on it and locate the "Quality ID" located under the blue "Measure Number" section. Remembering the Quality ID, go back to the opening page and click on "About" in the upper right corner of the opening page and then on "Resource Library". You will be redirected to click the hyperlink "Resource Library to CMS.gov." Midway down the page, under "Find resources by topic," go to "MIPS" and then "Quality" and you will see the "Quality Measure Specifications" which contains the G-codes you need to report, as well as the allowable office visit and / or procedure codes with which they may be submitted.

The **dermatology measure set is** shown below. If you elect to use the dermatology measure set in lieu of selecting measures from the complete list, you must report six of the measures, including an outcome or high-priority measure, unless fewer are applicable to your practice. Of the 12 measures, six are clearly dermatologic (shown in orange) and the others are **cross-cutting measures**, or measures that CMS considers generally applicable to all specialties. Three of these measures (those underlined) can be reported by claims, one is an outcome measure and seven are high-priority measures.

2018 Dermatology Measure Set
1. "Melanoma Continuity of Care – Recall System" (Quality #137)*
2. "Melanoma: Coordination of Care" (Quality #138)*
3. "Melanoma: Overutilization of Imaging Studies" (Quality #224)*
4. "Biopsy Follow-Up" (Quality #265)*
5. "Psoriasis: Clinical Response to Oral Systemic or Biological Medication" (Quality #410)**
6. "BCC/SCC: Biopsy Reporting Time" (Quality #440)
7. "Screening for High Blood Pressure" (Quality #317)
8. "TB Prevention for Psoriasis, Psoriatic Arthritis"(Quality #337)
9. "Closing the Loop: Receipt of Specialist Report" (Quality #374)*
10. "Documentation of Current Medications" (Quality #130)*
11. "Tobacco Use And Help With Quitting Among Adolescents" (Quality #402)
12. "Tobacco Use: Screening and Cessation Intervention" (Quality #226)

*"High priority measures" that can substitute for an outcome measure.
**An outcome and high priority measure.
Measures 2, 3, 4 and 10 were topped out in performance year 2017.
Measures 7, 10 and 12 can be reported by claims.

You do ***not*** have to use measures from this set. It is highly suggested that you review all available quality measures and select those most relevant to *your* practice and easiest to report. Rather than using the dermatology measure set, I found the measures on page 10 easiest to integrate into my practice and document. I have chosen to report quality measures by claim so that I only need to report on 60 percent of my Medicare Part B patients, *not* all of my patients. Several measures can be answered on a survey sheet when

patients sign in. After reviewing the answers with my patients, I initial and date the sheet. Most of the measures I have selected are required only *once* per performance period and are easy to ask or perform. Screening for high blood pressure, for example, is quite easy. You can purchase an automated blood pressure device from Amazon or your medical supplier for less than $30. If the patient's blood pressure is elevated as defined in the measure's specifications, simply refer them to their primary care physician and document their record. Since I was already documenting my patients' medications, I selected this measure despite it being topped out. We are very careful to be sure it is reported on 100 percent of my Medicare Part B patients (again, I am reporting quality measures by claim) so that we will receive 10 points for this quality measure this year. By reporting more than one high priority measure, I will earn bonus points.

CLIFF'S CHOICES
1. Care plan (Quality #47)*
2. Influenza Immunization (Quality #110)
3. Pneumococcal Vaccination (Quality #111)
4. Documentation of Current Medications (#130)*
5. Screening for High Blood Pressure and Follow-UP (Quality #317)
6. Tobacco Use: Screening and Cessation Intervention (Quality #226)

*High priority measures

A **topped-out measure** is one whose median performance rate is 95 percent or higher (the median is the middle number in a list of numbers.) These measures are being reported so successfully that meaningful distinctions between clinicians and improvement in performance cannot be made. CMS intends to limit the quality points available to seven points (rather than 10) on six measures this year if they are "again identified as topped out in the benchmarks for the 2018 MIPS performance period." One of these measures is quality measure #224, which involves overutilization of imaging studies in melanoma. If you are merely trying to avoid a penalty, it may not matter whether a measure is topped out. However, when seeking to attain a bonus, it is usually best to avoid measures that are topped out. In the future, topped-out measures will be evaluated and eliminated on a four-year timeline after each is reviewed and given final consideration.

Advancing care information This performance category promotes the use of electronic technology and facilitates the exchange of information among providers. You need to report data on all patients, not just Medicare beneficiaries. It cannot be reported using claims.

There are three components to this category: Base measures, performance measures and bonus measures. In order to get full credit in this category, you need to score 100 points. The **base measures**, which are worth 50 points, must be reported in order for you to obtain *any* credit for the advancing care information category. In other words, the base measures are "all or none". Once you have reported the base measures, **performance measures** make an additional 90 points available. Certain base measures will also give you credit as performance measures if you report more than one patient. Finally, you can get a **five percent bonus** if you report an additional public health agency or clinical data registry not reported under the performance score, a **10 percent bonus** if you report at least one of 30 specific improvement measures using certified electronic health record technology (CEHRT), as well as an **additional bonus of 10 percent** if you report using 2015 CEHRT only. By earning all three bonuses, you can get 25 percent more points in your advancing care information score. Although there are more than 100 possible points in this category, any score of 100 or more points will give you the maximum 25 points you can earn in advancing care information towards your composite performance score.

The final rule allows small practices facing "**significant hardship**" to apply for an exemption from the advancing care information performance category. The practice "must demonstrate in the application that there are overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirements." Although small practices are not subject to a 5-year limitation on this exemption, they will need to re-apply annually. Interestingly, the final rule also states, "We do not intend to require documentation of the overwhelming barriers."

Providers who write fewer than 100 "permissible prescriptions" during the performance period can claim an exemption from the "Electronic Prescribing" measure. Additionally, any MIPS-eligible clinician "who receives transitions of care or referrals or has patient encounters in which the MIPS-eligible clinician has never before encountered the patient fewer than 100 times during the performance period" may request an exemption from the "Health Information Exchange" measure. Clinicians will still get full credit for the base score in the advancing care information performance category if they are eligible for either or both of these exemptions.

MIPS-eligible clinicians whose electronic health technology is decertified may apply for an exemption. The application must demonstrate that the "clinician made a good faith effort to adopt or implement another CEHRT." If the exemption is granted, the advancing care information performance category will be assigned a zero percent weight in the composite performance score for that year.

Improvement activities This is the only MIPS category not related to a prior legacy program. Initiated with the implementation of MIPS in performance year 2017, this category rewards practitioners for conducting activities which directly affect patient care, such as increasing the availability of providers or seeing patients in a timely fashion. Although many of the 113 activities are not relevant to dermatology, many others reflect activities that we are routinely performing but may not have previously had the opportunity to report. We can now report and get credit for them! For performance year 2018, 21 of the improvement activities are *new* and 27 activities approved for 2017 have been modified.

Each activity is worth 10 or 20 points depending upon whether it is a "medium" or "high" value measure. You need to get 40 points needed to get full credit for this performance category and, therefore, 15 points towards your

composite performance score. This means that you need to perform and document four "medium" value or two "high" value measures. However, if you are in a small practice (15 or fewer practitioners) each measure is worth *double*. That means that those in small practices only need to perform and document two "medium" or a single "high" value measure to get full credit for this category! You will be able to attest to these activities on CMS's website (or on many proprietary registries).

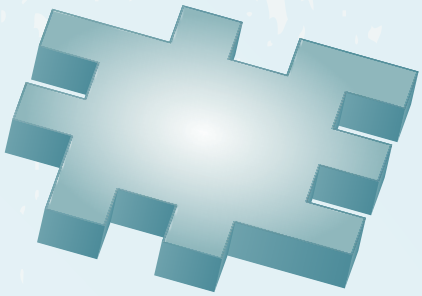
You are *already* performing many of these activities. For example, are you providing "same-day or next-day access to a consistent MIPS eligible clinician, group, or care team when needed for urgent care or transition management"? In other words, if a patient calls your office because they are bleeding or having a drug reaction ("urgent" problems) would you or someone in your office ("care team") see them that day or the next day? Of course you would! If you are not doing so, you do not have a MIPS problem – you have a malpractice problem.

Cost Also referred to as "resource use," your score in this performance category will count for 10 percent of your composite performance score. Your score in this category will be calculated by CMS and you will *not* need to submit any cost information. It will be determined by two factors: **Medicare spending per beneficiary (MSPB)** and **total per capita cost per attributed beneficiary**. There is a 35-case minimum for MSPB and a 20-case minimum for the total per capita cost. Both of these factors are reflected in your Quality and Resource Use Report (QRUR) and will be adjusted for risk factors as they were under the legacy value-based modifier program. Cost measures will be benchmarked against other MIPS eligible clinicians during the performance period and, therefore, will not be based on the previous year. Episode-based measures, which were calculated for performance year 2017, will *not* be considered for 2018. Drugs will be attributed to providers "as feasible and applicable." Critical to dermatologists, physician-patient relationship codes currently being developed will determine the provider to which potentially expensive hospitalizations will be attributed.

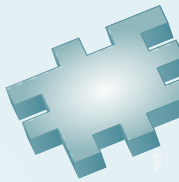
Medicare spending per beneficiary reflects the cost of hospitalizations. It includes all Part A and Part B expenses paid on behalf of a beneficiary from the third day prior to admission (to account for preadmission testing) through the thirtieth day after discharge. The total per capita cost per beneficiary will take into account all expenses paid on behalf of a beneficiary for the entire 12-months of the year. Both of these determinations will be calculated by CMS and, unlike the other performance categories, will not require your submitting any data.

You can also earn an additional **10 percent bonus** in the cost performance category based upon you **improvement** since last year.

Payment adjustments Based upon your composite performance score in 2018 you will be eligible for a **five percent** bonus (or penalty) in 2020. MIPS is budget neutral. Therefore, the exact amount of one's adjustment will depend upon the performance of all providers. It is possible, due to scaling, that bonuses could be three times the cited amount, or up to 15 percent for the top performers. The penalty, however, can *never* exceed five percent in 2020.

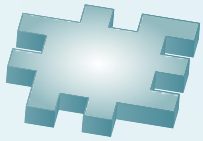


It is enlightening to remember that prior the implementation of the QPP it was possible for a provider to receive up to a 10 percent penalty based upon their performance in 2016. Furthermore, no bonuses were available (as a result of the legacy programs) in 2015 through 2018.



Internet availability The Secretary of HHS is required to make available on the internet "in an easily understandable format" the MIPS score for each practitioner, including data on "each performance category." This information will, therefore, be available to patients, managed care organizations, etc.

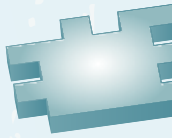
Advanced APMs To qualify as an advanced APM, the plan must require participants to use certified electronic health record technology, incorporate quality measures comparable to those in the performance category of MIPS, and must require that participants bear "more than nominal risk." In 2017 there were only seven advanced APMs and several were either available in a limited number of states or were restricted to certain specialties. Furthermore, in order to have been a qualified provider last year or to be one in 2018, you must have received or receive either 25 percent of your income or 20 percent of your patients through an advanced APM. It is not surprising, therefore, that only 139 dermatologists nationwide were qualified participants in advanced APMs in 2017.



Practitioners who try to be qualified practitioners but only see at least 20 percent of their income or 10 percent of their patients in 2018 are **partially qualified participants** and may elect to opt out of MIPS. Although they will receive any bonuses or penalties provided by their APMs, they will not receive a five percent bonus from CMS.

Beginning in 2019, CMS intends to provide an "all-payer option." This would provide participants in non-Medicare APMs (which meet the Medicare advanced APM requirements) the opportunity to reap the benefits of practitioners in Medicare advanced APMs. These participants would, however, still need to see a certain percent of their patients through Medicare advanced APMs.

MIPS vs. advanced APMs Will your payments in 2020 be higher under MIPS or advanced APMs? It depends. Based upon your composite performance score in 2018, you can earn a payment adjustment of up to five percent in 2020 under MIPS. Although this could be as high as 15 percent due to scaling, this is unlikely since it will only occur if a substantial number of practitioners are penalized since MIPS is budget neutral. MIPS is laced with numerous bonuses within performance categories and provides significant payment adjustments for being in a small practice, having a high composite performance score, as well as for treating patients with complex medical problems.



MIPS BONUSES

PERFORMANCE CATEGORY

Quality Measures: up to 10% for reporting certain measures and/or using CEHRT *as well as* up to 10% for improvement

Advancing Care Information: 5% for reporting to additional registries; 10% for reporting certain improvement Activities; *and* 10% for using 2015 CEHRT

Improvement Activities: *You are already doing many of these activities!*

Cost: Up to 1% for improvement

COMPOSITE PERFORMANCE SCORE

Small practices: 5 points

Complex patients: up to 5 points

Exceptional performance: Bonus payment of up to 10%

MIPS BONUSES – SMALL PRACTICES

EXCLUSIONS AND ELIGIBILITY

Low-volume threshold: You are excluded if you bill $90,000 or less in allowable Part B charges or see 200 or fewer beneficiaries

Virtual Groups: option to join with other solo or small practices to submit data as a group

PERFORMANCE CATEGORY

Quality Measures: small practices get 3 points even if measures submitted do not meet the data completeness requirement

Improvement Activities: small practices need only 1 high-value activity or 2 medium-value activities for full credit

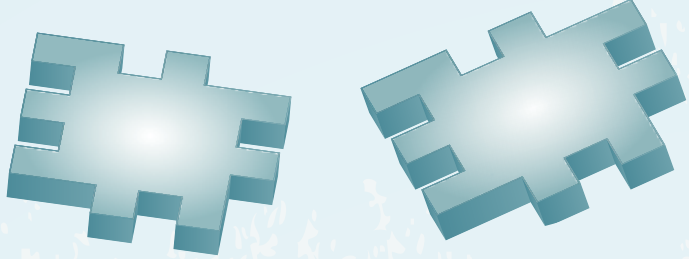
Advancing Care Information: may apply for a hardship exception and have ACI reweighted to zero

Alternatively, if you are a qualified provider in an advance APM you will receive a five percent bonus *in addition* to the incentives built into the APM and be exempt from MIPS. Since incentives within advanced APM vary, it is difficult to make a blanket statement concerning the financial benefit of any given APM without knowing this specific information.

MISCELLANEOUS PROVISIONS

Medigap policies Effective Jan. 1, 2020, "a Medicare supplemental policy that provides coverage of the part B deductible…may not be sold or issued to a newly eligible Medicare beneficiary." [MACRA, Section 101] Patients must have attained age 65 before Jan. 1, 2020 to be eligible to purchase a Medigap policy that covers their deductible. This provision will not, however, prohibit Medigap policies from covering copayments.

Income related premiums Patients with higher incomes will pay more for Medicare coverage. MACRA increases the threshold at which beneficiaries pay 35 percent or 50 percent of the Medicare actuarial value, thus lowering the payments from lower income individuals. It also decreases the threshold at which beneficiaries pay 65 percent or 80 percent of the



Medicare actuarial value, thus increasing payments from those with higher incomes.

NPI number on pharmacy claims "For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug…to include a prescriber National Provider Identification." [MACRA, Section 507(A)]

Prohibition of Social Security numbers A Social Security number may not be "displayed, coded or embedded on the Medicare card issued to an individual" later than April 2019.

PEARLS

1. Be aware of dated information! Even information released last year may be outdated, misleading, or factually incorrect.
2. When submitting quality measures, be sure you meet the case volume (20 cases) and data completeness (60 percent) requirements.
3. There are over two hundred quality measures and dozens of improvement activities available. Chose those most compatible with your practice and easiest to report.
4. Review the measure specification and data validation (documentation) requirements for all quality, advancing care information, and improvement activity measures you report. Several have changed since 2017.
5. When reporting quality measures, try to avoid those that are topped out to get the best possible bonus.
6. Bill $0.01 with each reported measure so that your clearing house does not strip out the measure and CMS never receives it.
7. Visit *qpp.cms.gov* to sign up for free updates.

QUESTIONS?

The single most authoritative, up-to-date source for information is CMS's website, *qpp.cms.gov*.

Access "Help and Support" at the bottom of the website's home page and find webinars, videos, online courses and links to the Quality Improvement Organization (QIO) and the Small, Underserved and Rural Support (SURS) organization serving your state. ■

Disclaimers: Although all efforts have been made to be accurate and current, CMS may modify the implementation of the QPP. Reliance should *only* be placed on the final rule and subsequent interpretations and determinations by CMS, which can be found at *qpp.cms.gov*.

Several of the quality, advancing cares information and improvement activity measures have been changed from the 2017 performance year. Review the measure specification and data validation (documentation) requirements for all measures you report.

The information is not intended as legal guidance and reflects the opinion of the author not necessarily ASDS / ASDSA..

