Delivering Care Under the MACRA Final Rule

Implementation Considerations and Implications

November 18, 2016
Value-Based Purchasing ("VBP") Roadmap

1. Fee-for-Service
2. Fee-for-Service with Incentives for Efficiency + Quality
3. Managed Care with Quality Incentives
4. Population Health
5. Risk-Based Managed Care
VBP Goals For Medicare

- In January 2015, HHS Secretary Burwell declares VBP goals for the Original Medicare program
- As of March 2016, HHS announced that 30 percent of Medicare payments are tied to alternative payment models that reward quality over quantity

- Fee-for-Service Tied to Quality – Readmission & HAC Penalties
- Alternative Payment Models – ACOs, Bundles, etc.

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>68%</td>
<td>50%</td>
</tr>
<tr>
<td>2014</td>
<td>20%</td>
<td>90%</td>
</tr>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
</tr>
<tr>
<td>2018</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>
Medicare Access and CHIP Reauthorization Act ("MACRA"): Physician Payment Reform

- Federal legislation was enacted in April 2015 that repeals the Sustainable Growth Rate ("SGR") formula under the Medicare Physician Fee Schedule
  - Eliminates physician payment rate cuts under SGR; sets annual updates of 0.5% from July 1, 2015 through the end of 2019
  - In 2019 and after, physician payments vary based on quality performance and value through:
    - Merit-Based Incentive Payment System ("MIPS") or
    - Advanced Alternative Payment Models ("APMs")

- October 14, 2016 – CMS issued a final rule implementing MIPS and APM incentives under the new "Quality Payment Program"
  - Available at https://qpp.cms.gov/education
## The Future of Physician Payments: Summary of Payment Mechanisms

<table>
<thead>
<tr>
<th>MIPS</th>
<th>APM</th>
<th>Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2019 and beyond: MIPS payment adjustments</td>
<td>• APM-specific rewards</td>
<td>• APM-specific rewards</td>
</tr>
<tr>
<td>• 2026 and beyond: 0.25% update</td>
<td>• Favorable MIPS scoring</td>
<td>• 2019-2024: 5% bonus payment</td>
</tr>
<tr>
<td></td>
<td>• 2019 and beyond: MIPS payment adjustments</td>
<td>• 2026 and beyond: 0.75% update</td>
</tr>
<tr>
<td></td>
<td>• 2026 and beyond: 0.25% update</td>
<td></td>
</tr>
</tbody>
</table>
Will This All Change Under the New Administration?

- MACRA is the result of broad bipartisan agreement
- The financial incentives to move physicians toward APM participation were part of the bipartisan agreement → Republican administration is not likely to completely eliminate mechanisms that allow CMS to create APMs for physicians
- Republican administration may be more sympathetic to further administratively easing the implementation of MIPS but otherwise will proceed with the law
MACRA Proposed Rule: Feedback from Stakeholders

- Comments to the MACRA proposed rule were due on June 27, 2016
  - Over 3,900 public comments submitted from various stakeholders (individuals, healthcare professionals, professional societies, trade associations, hospitals, health systems, manufacturers, insurers, employers, patient advocacy groups, state/local governmental entities, etc.)

- Areas of concern included in public comments:
  - Implementation timeframe is too fast
  - MIPS reporting and measurement system is too complex
  - Performance period is too far removed from the reward/penalty
  - Bar is set too high for participation in Advanced APMs
  - MIPS/APM requirements will lead to the disappearance of solo/small practices
  - Primary care focused; limited Advanced APM opportunities for specialists
MACRA Implementation: Moving From Proposed to Final

“Plans for the Quality Payment Program in 2017: Pick Your Pace”

As the baby boom generation ages, 10,000 people enter the Medicare program each day. Facing that demand, it is essential that Medicare continues to support physicians in delivering high-quality patient care. This includes increasing its focus on patient outcomes and reducing the obstacles that make it harder for physicians to practice good care.

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) offers the opportunity to advance these goals and put Medicare on surer footing. Among other policies, it repeals the Sustainable Growth Rate formula and its annual payment cliffs, streamlines the existing patchwork of Medicare reporting programs, and provides opportunities for physicians and other clinicians to earn more by focusing on quality patient care. We are referring to these provisions of MACRA collectively as the Quality Payment Program.

We received feedback on our April proposal for implementing the Quality Payment Program, both in writing and as we talked to thousands of physicians and other clinicians across the country. Universally, the clinician community wants a system that begins and ends with what's right for the patient. We heard from physicians and other clinicians on how technology can help with patient care and how excessive reporting can distract from patient care; how new programs like medical homes can be encouraged; and the unique issues facing small and rural non-hospital-based physicians. We will address these areas and the many other comments we received when we release the final rule by November 1, 2016.

But, with the Quality Payment Program set to begin on January 1, 2017, we wanted to share our plans for the timing of reporting for the first year of the program. In recognition of the wide diversity of physician practices, we intend for the Quality Payment Program to allow physicians to pick their pace of participation for the first performance period that begins January 1, 2017.

During 2017, eligible physicians and other clinicians will have multiple options for participation. Choosing one of these options would ensure you do not receive a negative payment adjustment in 2019. These options and other supporting details will be described fully in the final rule.

First Option: Test the Quality Payment Program.

With this option, as long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.

Second Option: Participate for part of the calendar year.

With this option, as long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.

Third Option: Participate for the full calendar year.

“... We need to launch this program so that it begins on the right foot. And that means that every physician in the country needs to feel like they are set up for success. ... We remain open to multiple approaches. So some of the things that are on the table that we are considering include alternative start dates, looking at whether shorter periods could be used, and finding other ways for physicians to get experience with the program before the impact of it really hits them.”

Andy Slavitt, CMS Acting Administrator
Senate Finance Committee Hearing
July 13, 2016
MACRA Final Rule: Changes to Make Quality Payment Program More Accessible

- **“Pick-Your-Own-Pace” Approach**
  - The first performance year (2017), and possibly some or all of the second performance year (2018), will be a transition period for clinicians
  - Clinicians will be able to choose one of four options for participating in MIPS or APMs

- **Reducing the Reporting Burden**
  - CMS decreased the number of measures required to meet MIPS performance standards and eliminated the Resource Use Measures for 2017

- **Relief for Small Practices**
  - CMS revised the low-volume threshold so that more small practices would be excluded from participation in MIPS

- **Increasing Opportunities for Participation in Advanced APMs**
  - CMS plans to expand the number of Advanced APMs available for participation in 2017 and 2018
"Pick-Your-Own-Pace" Approach: MIPS/APM Participation During Transition Period

<table>
<thead>
<tr>
<th>MIPS Test Pace</th>
<th>MIPS Partial Year</th>
<th>MIPS Full Year</th>
<th>Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinicians report 1 quality measure, 1 improvement activity, or the 5 required ACI measures</td>
<td>• Clinicians report data for at least a full 90-day period</td>
<td>• Clinicians report data for a full 90-day period or for up to a full year</td>
<td>• Clinicians participate in an Advanced APM in 2017</td>
</tr>
<tr>
<td></td>
<td>• Clinicians report more than 1 quality measure, more than 1 improvement activity, or more than the 5 required ACI measures</td>
<td>• Clinicians report 6 quality measures or one specialty or subspecialty-specific measures set, up to 4 improvement activities, and 5 required ACI measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Avoid a negative MIPS payment adjustment and possibly receive a positive MIPS payment adjustment</td>
<td>• Maximum potential for a positive MIPS payment adjustment and a possible bonus for “exceptional performance”</td>
<td></td>
</tr>
</tbody>
</table>

A clinician that is not exempt from MIPS and does not participate in any of these 4 options will receive a negative 4% payment adjustment in 2017
Overview of Advanced APMs

- From 2019-2024, participants in Advanced APMs are eligible for an annual lump-sum bonus of 5% of estimated Medicare payments for the preceding year
  - The bonus payment would be in addition to any shared savings bonuses or fees that the clinician receives for participating in the Advanced APM

- Advanced APMs must require participating clinicians to:
  - Take on “more than nominal” financial risk (or participate in certain patient-centered medical homes)
  - Report quality measures that are comparable to the measures adopted under MIPS
  - Use certified EHR technology (“CEHRT”)
Final APM Policies: Identifying Advanced APMs

MACRA defines APMs to include:

- Models being tested by the CMS Center for Medicare and Medicaid Innovation (under section 1115A of the Social Security Act, other than a Health Care Innovation Award)
- Accountable Care Organizations (“ACOs”) participating in the Medicare Shared Savings Program
- Models tested under the Health Care Quality Demonstration Program
- Demonstrations required by Federal Law

Advanced APMs identified in the final rule:

- Medicare Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus
- Oncology Care Model (Two-Sided Risk Arrangement)
Final APM Policies: Expanding the List of Eligible Advanced APMs

- CMS issued a proposed rule on July 25, 2016 that:
  - Implements a new mandatory bundled payment program for cardiac care
  - Expands the existing Comprehensive Care for Joint Replacement (“CJR”) model to include other hip surgeries
  - Introduces a new model to increase use of cardiac rehabilitation
  - Creates new pathways for bundled payment models to **qualify as Advanced APMs**

- For 2018, CMS expects that the following models will be Advanced APMs:
Final APM Policies: Financial Risk Standard

- In general, financial risk occurs if CMS:
  - withholds payment,
  - reduces payment rates, or
  - requires an Advanced APM Entity to make payments to CMS if actual expenditures exceed expectations

- The financial risk standard does not include reductions in otherwise guaranteed payments made under the terms of the APM

- CMS declined to include business expenses in the final financial risk standard

APMs with no downside risk do not qualify as Advanced APMs
Final APM Policies: “More than Nominal”
Financial Risk

Risk standard for 2017 and 2018

**Total Amount Owed/Forgone:** equal to at least:

1. 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (“revenue-based standard”)
2. 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (“benchmark-based standard”)

* CMS did not finalize marginal risk and minimum loss rates included in the proposed rule

- **Example:**
  - APM Entity’s Medicare Parts A and B revenue = $10 million
    - **Revenue-based standard:** at least $800,000 of the APM Entity’s revenue must be at risk
  - Benchmark spending for the services and population in the APM = $25 million
    - **Benchmark-based standard:** at least $750,000 of the APM Entity’s expenditures must be at risk
Final APM Policies: “Significant Share” of Revenue

- Clinicians must receive a “significant share” of their revenue through participation in an advanced APM to be eligible for the 5% bonus.
- Partial qualifying mechanism allows clinicians that fall short of revenue requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS.
- Favorable scoring under the MIPS clinical practice improvement activities (“CPIA”) performance category.
Final APM Policies: Determining Qualified APM Participants

- Advanced APM participants eligible for bonus payment determined based on CMS’s review of the Advanced APM Entity’s Participation List on the following dates:
  - Proposed Rule
    - Dec. 31
    - Aug. 31
    - Jun. 30
    - Mar. 31
  - Final Rule
    - Dec. 31
    - Aug. 31
    - Jun. 30
    - Mar. 31

- 50% of Advanced APM participants* must use CEHRT to document care and communicate with patients and other health care professionals

- QP Status based on:
  - APM
  - APM Entity
  - TIN/NPI Combination

* CMS did not finalize the proposal to increase the threshold for CEHRT use to 75% in 2018
Final APM Policies: Other Payer Advanced APMs

- Starting in 2021 (based on performance in 2019), participation in Other Payer Advanced APMs may allow clinicians to qualify for 5% APM bonus payment.

- Other Payer Advanced APMs must meet 3 criteria:
  - Require use of CEHRT
  - Apply quality measures comparable to MIPS quality measures
  - Include a payment arrangement that:
    - Requires participants to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures, or
    - Is a Medicaid Medical Home Model

- Other Payer Advanced APMs may include:
  - State Medicaid programs
  - Commercial payers
  - Medicare Advantage (“MA”) plans
Final APM Policies: MA Plan Participation

- Clinician participation in MA plans could qualify as an Other Payer Advanced APM, but only if the 3 criteria are met

- An arrangement where the MA plan pays the provider on a FFS basis would not be considered an Other Payer Advanced APM → there is no risk connected to actual cost of care exceeding projected cost of care

- Report to Congress looks at incorporating APMs into MA plans
  

Source: Kaiser Family Foundation analysis of CMS data, 2016
Advanced APM Participation: Expectations and Considerations

- CMS expects that Advanced APM participation will increase over time

<table>
<thead>
<tr>
<th>Number of Clinicians</th>
<th>2017 (Proposed Rule)</th>
<th>2017 (Final Rule)</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Bound</td>
<td>30,658</td>
<td>70,000</td>
<td>125,000</td>
</tr>
<tr>
<td>Upper Bound</td>
<td>90,000</td>
<td>120,000</td>
<td>250,000</td>
</tr>
</tbody>
</table>

- Clinicians need to determine where they stand
  - Are you currently participating in an APM or a patient-centered medical home? If not, do you plan to start participating in one in 2017?
    - CMS plans to re-open applications for CPC+ and Next Generation ACO models and expand the number of eligible Advanced APMs in 2017 (for participation in 2018)
  - Is your APM on the current list of Advanced APMs, or is it one of the bundled payment models CMS has proposed to expand to meet Advanced APM criteria?
  - Does the APM include the reporting of quality measures that are comparable to MIPS measures, use of CEHRT, and financial risk?
  - How much of your revenue is tied to the APM?
Advanced APM Participation: Understanding the Economics

- Clinicians need to weigh the benefits and risks of Advanced APM participation
  - Does the 5% bonus payment outweigh the risks associated with Advanced APM participation (e.g., start-up/business expenses, opportunity costs, downside risk)?
  - Are you ready for a move to APM participation (organizationally, clinically, financially)?
  - Does participation in an APM that qualifies for scoring benefits under MIPS make more sense because it may be easier to achieve positive MIPS payment adjustments and not be subject to downside risk through the APM?
  - How can your efforts with other payers impact Advanced APM qualification?

**Important:** moving toward an APM may be necessary in the long-run, given that those participating in Advanced APMs receive higher annual payment updates starting in 2026 – **0.75% vs. 0.25%** – and the impact of compounding over time
Advanced APM Participation: Moving Forward If There Is No Existing Pathway

- If there are no existing opportunities to participate in an Advanced APM, clinicians should consider:
  - Submitting proposals to the Physician-Focused Payment Model Technical Advisory Committee ("PTAC")
  - Negotiating payment arrangements with other payers that would qualify as Other Payer Advanced APMs
  - Participating in APM development and adoption efforts through the Health Care Payment Learning & Action Network ("HCP-LAN")
Overview of MIPS

- MIPS streamlines multiple quality programs to link FFS payments to quality and value
  - Current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (“PQRS”) penalties sunset at the end of 2018
  - Reporting requirements roll into a single program

- MIPS performance starts in 2017
- MIPS payment adjustments start in 2019
Final MIPS Policies: Eligibility for Participation

- MIPS **applies to** physicians, nurse practitioners, clinical nurse specialists, physician assistants, and certified registered nurse anesthetists
  - CMS may add other health care professionals in 2021 and beyond
    - This could include physical or occupational therapists, speech-language pathologists, audiologists, certified nurse midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals

- MIPS **does not apply** to:
  - Clinicians in their first year of Medicare Part B participation
  - Participants in Advanced APMs who qualify for the bonus payment
  - Clinicians below the low volume threshold
    - Low volume defined in **final rule** as:
      - Medicare billing charges \( \leq \$30,000^* \)
      - 100 or fewer Medicare patients

* CMS originally proposed \$10,000 for the low volume threshold
Final MIPS Policies: Payment Adjustments

- Based on the MIPS composite performance score, eligible clinicians will receive positive, negative, or neutral adjustments to their Medicare Part B base payment rate.
- MIPS adjustments are budget neutral → a scaling factor (up to three times) may be applied to the upward adjustments to make total upward and downward adjustments equal.

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum Adjustments to Medicare Part B Base Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>+/- 4%</td>
</tr>
<tr>
<td>2020</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>2021</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2022 and beyond</td>
<td>+/- 9%</td>
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</tbody>
</table>
Final MIPS Policies: Composite Performance Score Weights

- A single MIPS composite performance score will be calculated for eligible clinicians based on four weighted performance categories

**MIPS Performance Categories**

- **Quality** – PQRS measures
- **Resource Use** – Cost measures
- **Clinical Practice Improvement** – Care coordination, shared decision-making, expanding practice access
- **Advancing Care Information** – Meaningful use measures

* CMS originally proposed that Resource Use measures would account for 10% of the composite performance score for 2019
Final MIPS Policies: Measure and Activity Reporting

**Quality**
- **Most participants**: report up to 6 quality measures, including an outcome measure, for a minimum of 90 days
- **Groups using web interface**: report 15 quality measures for a full year
- **Groups in MIPS APM**: report quality measures through the APM

**CPIA**
- **Most participants**: attest completion of up to 4 improvement activities for a minimum of 90 days
- **Groups with fewer than 15 participants (or rural/HPSA)**: attest completion of up to 2 activities for a minimum of 90 days
- **Participates in certified patient-centered medical home, comparable specialty practice, or APM designated as Medical Home Model**: automatically earn full credit
- **Participates in certain APMs**: automatically receive points based on requirements of participating in the APM (current APMs, full credit; future APMs, at least half credit)

**ACI**
- **Base score**: fulfill 5 required measures (Security Risk Analysis, e-Prescribing, Provide Patient Access, Send Summary of Care, Request/Accept Summary of Care) for a minimum of 90 days
- **Performance score**: submit up to 9 measures for a minimum of 90 days for additional credit
- **Bonus score**: report Public Health and Clinical Data Registry Reporting measures or use certified HER technology to complete certain activities in the CPIA performance category

**Cost**
- No data submission required (calculated by CMS from adjudicated claims data)
Final MIPS Policies: Data Submission Criteria and Timeframes

1st Performance Period

- January 1, 2017
- October 2, 2017
- November 2017
- December 2017
- January 2, 2018

- Submission Period for Registries, QCDRs, EHRs, Attestations (3 months) – 50% of patients meeting measure criteria*
- Submission Period for CMS Web Interface (8 weeks/TBD) – Sample of Part B patients provided by CMS

- Full-year reporting begins
- CMS Web Interface and CAHPS Administration group registration deadline
- Last day for 90-day reporting to begin
- CAHPS Administration Period (3 months) – sample of Part B patients provided by CMS

- Last day for 90-day reporting to begin
- CMS Web Interface and CAHPS Administration group registration deadline
- Full-year reporting begins

* CMS originally proposed data completeness thresholds of 90% for reporting through registries, QCDRs, EHRs and 80% for claims reporting; data completeness threshold will increase to 60% in 2018

Submission Deadline for claims reporting – 50% of applicable Part B patients*
# Final MIPS Policies: Quality Performance Category

<table>
<thead>
<tr>
<th>Weight (Year 1)</th>
<th>Assessment</th>
<th>Performance Standard</th>
<th>Submission</th>
</tr>
</thead>
</table>
| 60%            | Up to 6 measures, including 1 outcome measure*  
If outcome measure is not available, report 1 other high priority measure (appropriate use, patient safety, efficiency, patient experience, care coordination measures)  
If fewer than 6 measures apply to clinician, report on each applicable measure, or 1 specialty-specific measure set  
* CMS did not finalize proposal to require reporting of cross-cutting measure | Measure benchmarks to assign points  
➢ 3-10 points based on performance compared to benchmark when measure has a benchmark, has at least 20 cases, and meets data completeness standard  
➢ 3 points if measure does not have a benchmark, does not have at least 20 cases, or does not meet data completeness standard | Bonus points with a minimum floor for all measures, including points for high priority measures and submission using CEHRT | ➢ Claims  
➢ Qualified Clinical Data Registry ("QCDR")  
➢ Qualified registry  
➢ EHR  
➢ CMS Web Interface (groups of 25 or more)  
➢ CAHPS for MIPS survey  
➢ Administrative claims for all-cause hospital readmission measure (no submission required) |
Quality Performance Category

- Considerations:
  - Which measures are applicable to you/your practice?
  - When will you be ready to report measures?
    - One time, 90-day, full year reporting options
  - How many measures will you report?
    - 1 measure, more than 1 measure, 6 measure reporting options
  - What reporting mechanism makes the most sense for you/your practice?
  - What clinical/administrative processes need to be put in place to ensure that you perform well?
## Final MIPS Policies: Resource Use Performance Category

<table>
<thead>
<tr>
<th>Weight (Year 1)</th>
<th>Assessment</th>
<th>Performance Standard</th>
<th>Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>10 episode-based measures* related to: Mastectomy, Aortic/Mitral Valve Surgery, Coronary Artery Bypass Graft, Hip/Femur Fracture or Dislocation Treatment, Cholecystectomy and Common Duct Exploration,Colonoscopy and Biopsy, Transurethral Resection of the Prostate, Lens and Cataract Procedures, Hip Replacement or Repair, Knee Arthroplasty</td>
<td>Measure benchmarks to assign points</td>
<td>➢ Administrative claims (no submission required)</td>
</tr>
</tbody>
</table>

* CMS did not finalize all 41 proposed clinical condition and episode-based measures
Resouce Use Performance Category

Considerations:
- Which episode-based measures are applicable to you/your practice?
- Should your ordering patterns change based on resource use considerations?
- Although resource use will not be taken into account for the 2017 performance year, how can you prepare for 2018?

Note: CMS may add resource use measures in future years that address new areas of Medicare spending that have historically been excluded from these programs, such as drug spending.
### Final MIPS Policies: Clinical Performance Improvement Activities Performance Category

<table>
<thead>
<tr>
<th>Weight (Year 1)</th>
<th>Assessment</th>
<th>Performance Standard</th>
<th>Submission</th>
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</thead>
<tbody>
<tr>
<td>15%</td>
<td>Up to 4 improvement activities for a minimum of 90 days</td>
<td>Based on participation in finalized improvement activities in the following subcategories:</td>
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</tbody>
</table>
|                | For groups with fewer than 15 participants or if clinician is in rural or health professional shortage area (“HPSA”), up to 2 activities for a minimum of 90 days | - Expanded practice access  
- Population management  
- Care coordination  
- Beneficiary engagement  
- Patient safety and practice assessment  
- Participation in an APM  
- Promoting health equity and continuity  
- Social and community involvement  
- Achieving health equity  
- Emergency preparedness and response  
- Integration of primary care and behavioral health | - Attestation  
- QCDR  
- Qualified registry  
- EHR  
- CMS Web Interface (groups of 25 or more) |
|                |                                                                             | Based on participation as a patient-centered medical home or comparable specialty practice (full credit) |                                                |
|                |                                                                             | Based on participation as an APM (full credit for current APMs; for future APMs, assigned score will be at least half credit) |                                                |
Clinical Performance Improvement Activities
Performance Category

- Considerations:
  - Which improvement activities do you currently participate in?
  - Are there activities that you could realistically start, in order to maximize your potential score?
  - Is it realistic to participate in a patient-centered medical home or APM to gain more points?
  - Do any of the special considerations – for small groups and those in rural areas/HPSAs – apply to you?
  - What reporting mechanism would be most efficient?
  - Can you report any designated improvement activities using CEHRT to achieve a bonus score under the ACI performance category?
# Advancing Care Information Performance Category

<table>
<thead>
<tr>
<th>Weight (Year 1)</th>
<th>Assessment</th>
<th>Scoring</th>
<th>Submission</th>
</tr>
</thead>
</table>
| 25%            | **Report 5 measures for base score:**                                       | **Based on participation (base score) and performance (performance score)** | ➢ Attestation  
➢ QCDR  
➢ Qualified registry  
➢ EHR  
➢ CMS Web Interface (groups of 25 or more) |
|                | ➢ Security risk analysis  
➢ ePrescribing  
➢ Patient access  
➢ Summary of care measure  
➢ Send summary of care record | ➢ **Base score:** achieved by meeting the Protect Patient Health Information objective (security risk analysis measure) and reporting the numerator and denominator for additional required measures |                                                                          |
|                | **Earn performance score points for reporting:**                           | ➢ **Performance score:** between zero and 10 or 20 percent per measure based on measure reporting rate |                                                                          |
|                | ➢ Patient access  
➢ Patient-specific education  
➢ View, download and transmit  
➢ Secure messaging  
➢ Patient-generated health data  
➢ Summary of care measure  
➢ Send summary of care record  
➢ Clinical information reconciliation  
➢ Immunization registry reporting | ➢ **Bonus score:** up to 15 percent |                                                                          |
|                | **Earn bonus score for reporting improvement activities that utilize CEHRT and for reporting to public health or clinical data registries** |                                                                          |                                                                          |
Advancing Care Information Performance Category

- Considerations:
  - How do you currently use information technology or EHRs?
  - What opportunities are there for you to expand/enhance that use?
  - What measures are you able to report?
    - 5 base score measures, additional performance score measures, bonus score measures
  - What reporting mechanism would be most efficient?
MIPS Participation: Areas for Discussion

- CMS has taken steps to simplify reporting under MIPS and to allow 2017 to be a transition period
  - Most clinicians should be able to avoid a negative payment adjustment in 2017
  - Only those who do nothing at all will be penalized
  - Shifting competition considerations (for positive payment adjustment and “exceptional performer” adjustment) as CMS has excluded more clinicians and seeks to offer more opportunities for Advanced APM participation
MIPS Participation: Areas for Discussion (cont.)

- Clinicians need to use 2017 to determine how to fully participate in future years to avoid negative payment adjustments
  - Is consolidation or disaggregation necessary to maximize potential MIPS performance?
  - Are there partnerships or financial relationships that could help improve MIPS performance or ease the transition to APM participation?
  - Do you need to seek new vendor relationships to ensure you are able to report measures?
  - Are there certain types of vendors that you should consider working with to help improve MIPS performance? Are those vendors willing to take on risk/guarantee performance under MIPS?
Questions?

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Thank you.