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MIPS and APM Incentive under the Physician Fee Schedule Proposed Rule

May 13, 2016

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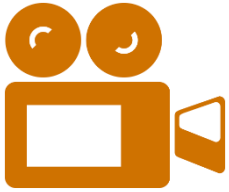

Recording

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Agenda

- Merit-Based Incentive Payment System (MIPS)
  - Eligibility
  - Quality
  - Resource Use
  - Advancing Care Information
  - Clinical Practice Improvement
  - Scoring and Payment Adjustment
- Alternative Payment Model (APM) Incentive
  - Advanced APMs
  - Qualifying and Partial Qualifying Participants
  - All-Payer and Medicare Payment Threshold
  - Incentive Payment
  - Physician focused Payment Models

MIPS-APM Proposed Rule

- Released April 27, published in May 9, *Federal Register*
- Performance categories & scoring methodology for MIPS
- Criteria for Advanced APMs to qualify for 5% bonus
- Performance period for the first year of MIPS (2019) is CY 2017
- Performance period for determining if you meet the threshold for participation in an APM is CY 2017
- CY 2018 will be the year to establish the APM bonus amount
- Finalized details expected by November 1, 2016 via the final Medicare Physician Fee Schedule rule

  ** All policies included in this deck are proposed**
- **Comments due June 27, 2016**

MIPS-APM Proposed Rule- How to Submit a Comment

- CMS proposed rule for the MIPS and APM Incentive
  - Comments due 60 days from the date of display (June 27, 2016)

1. Go to proposed rule
2. Click “Submit a Formal Comment”, the green button on the right-hand side of the page below the title.

OR

1. Go to http://www.regulations.gov
2. Type “CMS-5517-P” into the search box
3. Find “Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models” (should be first selection)
4. Click on “Comment Now”, the blue button to the right of the title.

Medicare Access and CHIP Reauthorization Act of 2015

Created in 1997, the SGR capped Medicare physician spending per beneficiary at the growth in GDP

The formula does not incentivize high-quality, high-value care

Since 2003, Congress has passed 17 laws to override SGR cuts

SGR creates uncertainty and disruption for physicians and other providers

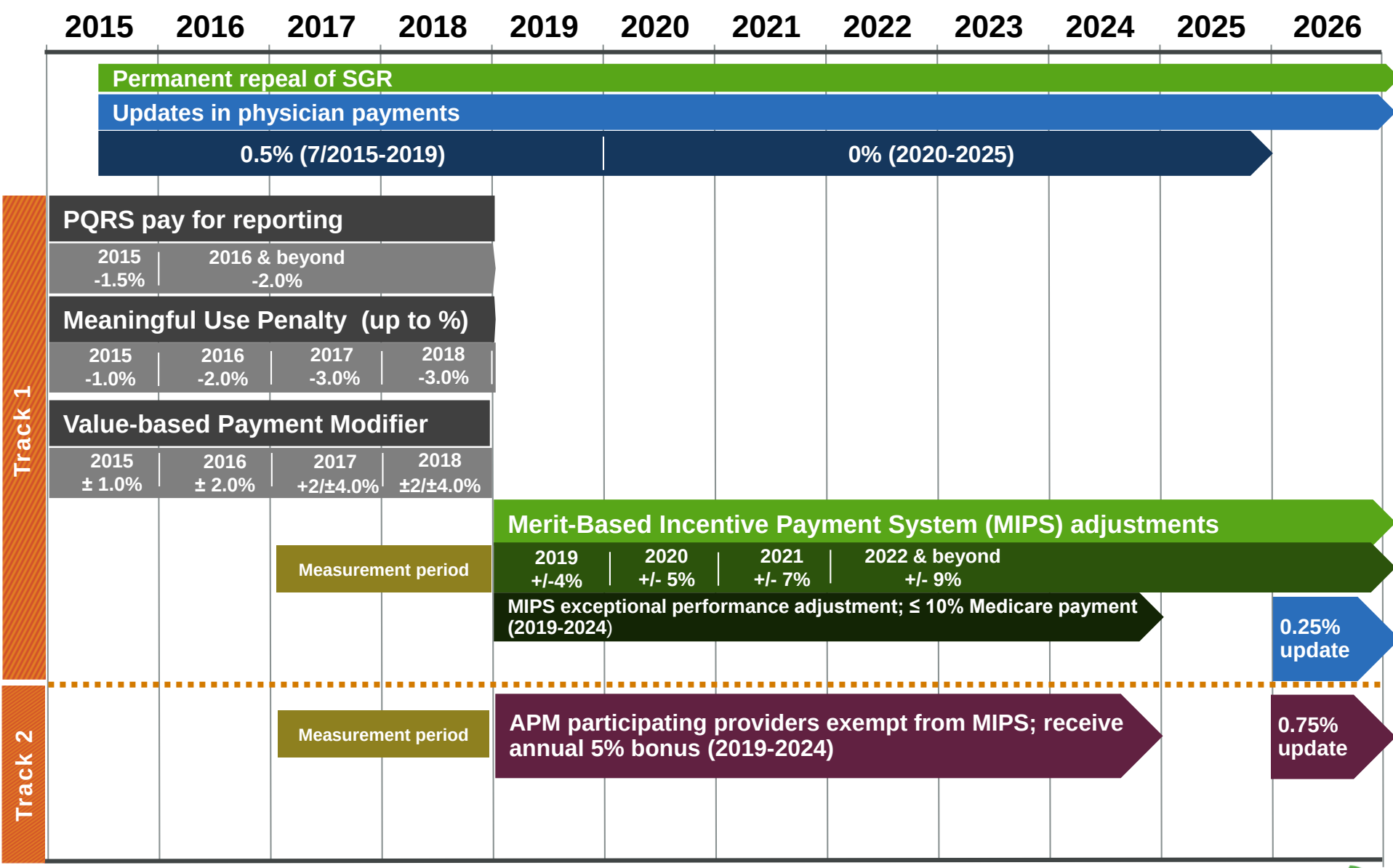
Most of $170B in 'patches' financed by health systems

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.

MACRA reform timeline

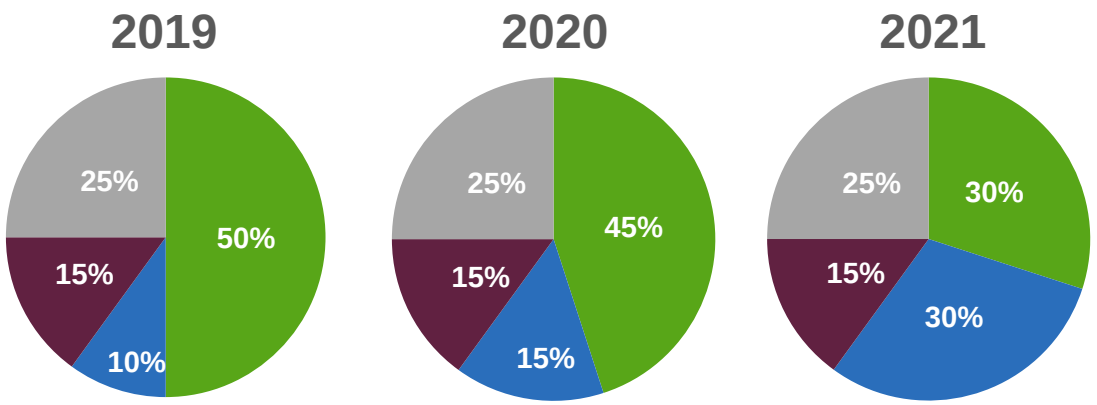
(Medicare Access and CHIP Reauthorization Act of 2015)



Merit-based Incentive Payment System (MIPS)

MIPS Overview

Jan 1- Dec 31, 2017 is the performance period for 2019 payment



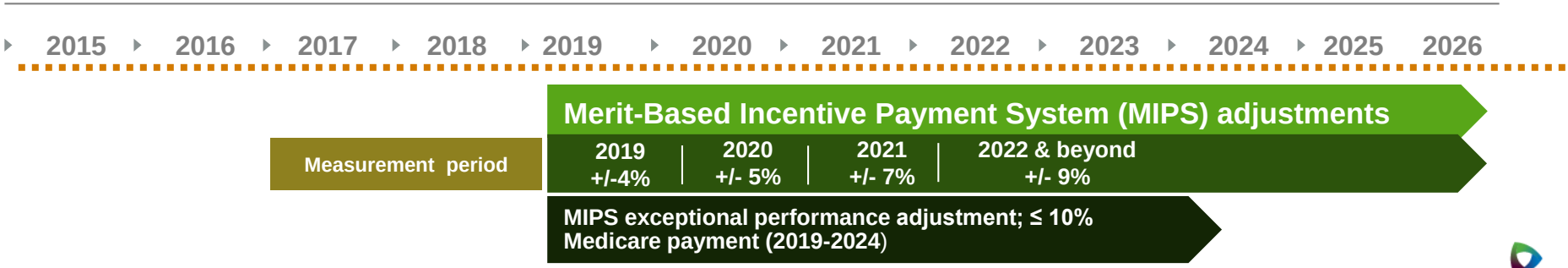
Quality — PQRS Measures, PQIs (Acute and Chronic), Readmissions

Resource use — MSPB, Total Per Capita Cost, Episode Payment

Advancing care information — Meaningful Use Objectives and Measures

Clinical practice improvement activities — Expanded access, population management, care coordination, beneficiary engagement, patient safety, and Alternative payment models.

- **Sets performance targets in advance, when feasible**
- **Sets performance threshold at median.**
- **Seeking input on how to consider improvement in year 2**



MIPS: Eligible Clinicians

- Physician, PA, NP, CNS, CRNA
- Exclusions
  - Qualifying APM Participants
  - Partial Qualifying APM Participants
  - New Medicare-enrolled eligible clinicians
    - » Enrolled during the performance year
    - » Not previously part of a group or billing under a different TIN
  - Clinicians below the low-volume threshold
    - » Less than $10,000 in charges AND
    - » Provides care for fewer than 100 beneficiaries
- CAHs
  - Method I- MIPS eligible clinicians subject to MIPS Adjustment
  - Method II- MIPS eligible clinicians who do not assign billing rights to CAH are subject to MIPS Adjustment
- RHC/FQHC
  - MIPS Adjustment does not apply to facility payment
  - MIPS eligible clinicians who bill for services under PFS are subject to MIPS adjustment

MIPS: Identifiers and Groups

- Identifiers
  - Individual- TIN/NPI
- Group- TIN
  - 2 or more MIPS eligible clinicians who have assigned billing rights to TIN
  - No virtual groups for the 1st performance year
- APM Participant Identifier
  - APM Identifier
  - APM Entity Identifier
  - TIN
  - NPI

MIPS: Reporting Mechanisms

Reporting Mechanism	Quality	RU	ACI	CPIA	Submission Deadline
Claims	✓ Individual only				90-day claims lag
Administrative Claims (no submission required)	✓	✓		✓	
Attestation			✓	✓	March 31 of year following performance period close
QCDR	✓+		✓+	✓	
Qualified Registry	✓+		✓	✓	
EHR	✓+		✓	✓	
CMS Web Interface	✓+ Option for groups 25+		Option for groups 25+	Option for groups 25+	8 weeks following performance period close (March 31)
Survey Vendor	Groups choosing to report CAHPS for MIPS				

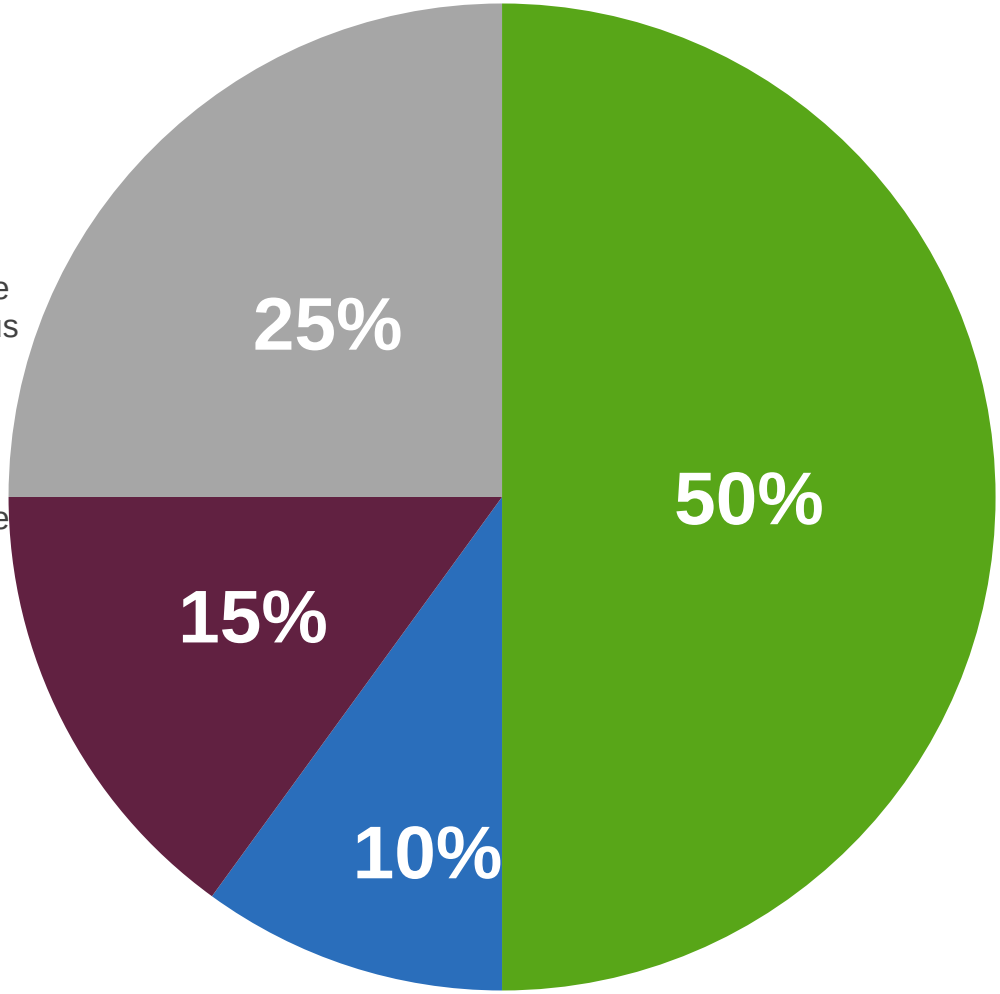
+ bonus points available

MIPS: 2019 Payment Year/ 2017 Performance Year

Advancing care information
100 points

Base Score
- eRx
- Patient electronic access
- Care Coordination
- Health Information Exchange
- Public Health Registry (bonus points possible)

Performance Score:
- Patient electronic access
- Care coordination
- Health Information Exchange



Quality
90 points*

6 measures (1 cross-cutting, one outcome)
PQIs- Acute and Chronic Readmissions (groups of 10+ only)

Bonus points:
- Outcome, appropriate use, patient safety, patient experience, care coordination measures
- Report using CEHRT or QCDR

Clinical practice improvement activities
60 Points*

High Weight- 20 points
Medium Weigh- 10 points

PCMH- 60 points
APM Participation- 30 points

Resource use
Points Vary*

MSPB, Total Per Capita Cost, Episode Payment

 * Total points possible vary by provider type and available measures

MIPS: Quality Data Submission Requirements

Measure Type	Submission Mechanism	Submission Criteria	Data Completeness
Individual	Part B Claims	6 measures; 1 cross-cutting, 1 outcome • If an outcome measure is not available, report another high priority measure. • If fewer than six measures apply, then report on each measure that is applicable. Measures selected from all MIPS Measures or a set of specialty specific measures .	80 percent of MIPS eligible clinician's Medicare Part B patients.
Individual or Groups	QCDR Qualified Registry EHR	6 measures; 1 cross-cutting, 1 outcome • If an outcome measure is not available, report another high priority measure. • If fewer than six measures apply, then report on each measure that is applicable. • At least one measure must include at least one Medicare patient Measures selected from all MIPS Measures or a set of specialty specific measures.*	90 percent of MIPS eligible clinician's or groups patients as all-payer data
Groups	CMS Web Interface	All measures included in the CMS Web Interface and • First 248 consecutively ranked and assigned Medicare beneficiaries • If less than 248, then the group would report on 100 percent of assigned beneficiaries.	Sampling requirements for their Medicare Part B patients
Groups	CAHPS for MIPS Survey	• The survey would fulfill the requirement for one cross-cutting and/or a patient experience measure towards the MIPS quality data submission criteria. • Survey will only count for one measure; must use another reporting mechanism to reach 6 measures • Administration November- February of reporting year, with a 6-month look back	Sampling requirements for their Medicare Part B patients

*Can report QCDR custom measures

MIPS: Quality Data Submission Requirements

- Non-patient facing MIPS eligible clinicians
  - Report on a specialty-specific measure set (may have less than 6 measures)
  - Report through a QCDR that can report non-MIPS measures
  - Be exempt from cross-cutting measures
- Facility-based clinicians
  - Request comment on
    - » Attributing a facility's performance to a MIPS eligible clinician for purposes of the quality and resource use performance categories
    - » Specific measures and settings for which CMS can use the facility's quality and resource use data as a proxy
    - » Automatic attribution or election

MIPS: Global and Population Based Measures

- AHRQ Prevention Quality Indicators (PQI)
  - Acute Condition Composite- Bacterial Pneumonia, UTI, Dehydration
  - Chronic Condition Composite- Diabetes, COPD, Asthma, HF
  - Minimum case size of 20
- All Cause Hospital Readmission Measure
  - Groups with 10 or more clinicians
  - Minimum case size of 200
- CMS seeks comments on additional measure or measure topics for MIPS

MIPS: Quality Performance Category Scoring (50%)

- Total possible points varies by group size, type of provider
- No “successful reporting” requirements
  - If less than 6 measures submitted still can receive a quality score
    - » Points awarded for each measure submitted
    - » Missing measures awarded 0 points
- Each measure awarded points on scale of 1-10 using decile breaks
  - Topped Out Measures
    - » Maximum points is lowered based on how clustered scores are
    - » Clinicians in same cluster awarded points equal to the midpoint of the cluster
    - » Measure considered topped out if variation coefficient is less than 0.10 and 75th and 90th percentiles are within 2 standard errors or median value is 95% or greater for process measures
  - Measures not scored, total possible points lowered
    - » Don’t meet the case minimum
    - » Measure does not have at least 20 eligible clinicians reporting
- Bonus Points
  - High Priority Measures (up to 5% of total possible score)
    - » 2 points for each outcome and patient experience measure (excludes required outcome measure)
    - » 1 point for each high priority measure (patient safety, efficiency, appropriate use, care coordination)
    - » Does not have to be a scored measure but must meet data completeness and case minimums
  - CEHRT/QCDR Submission (up to 5% of total possible score)
    - » 1 point if end-to-end reporting requirements are met
- Intend to develop a validation process to review clinicians inability to report

*Case minimum is 200 for readmissions measure

MIPS: Quality Performance Category Benchmarks

- Benchmarks from baseline period used to assign points
  - Baseline period- two years prior to performance period (2015 for CY 2019 payment)
  - Top decile awarded 10 points
  - 0% performance rate not included in benchmarks

Decile	Sample Quality Measure Benchmarks	Possible Points
Benchmark Decile 1	0-6.9%	1.0-1.9
Benchmark Decile 2	7.0-15.9%	2.0-2.9
Benchmark Decile 3	16.0-22.9%	3.0-3.9
Benchmark Decile 4	23.0-35.9%	4.0-4.9
Benchmark Decile 5	36.0-40.9%	5.0-5.9
Benchmark Decile 6	41.0-61.9%	6.0-6.9
Benchmark Decile 7	62.0-68.9%	7.0-7.9
Benchmark Decile 8	69.0-78.9%	8.0-8.9
Benchmark Decile 9	79.0-84.9%	9.0-9.9
Benchmark Decile 10	85.0%-100%	10

- Each benchmark must have 20 MIPS eligible clinicians meeting data completeness
- New measure benchmarks derived from performance period (2017 for CY 2019 payment)
- Separate benchmarks for each reporting mechanism
- Web Interface benchmarks same as MSSP
  - All scores below 30th percentile assigned 2 points
  - All measures scored

MIPS: Quality Performance Scoring Example

Measure	Measure Type	Points Based on Performance	Total Possible Points	Quality Bonus Points for High Priority	Quality Bonus Points for CEHRT
1	Outcome Measure using CEHRT	4.1	10	0 (required)	1
2	Outcome Measure	9.3	10	2	0
3	Patient Experience using CEHRT	10	10	2	1
4	High Priority using CEHRT	10	10	1	1
5	Process using CEHRT	9	10	0	1
6	Cross-cutting measure using CEHRT	8.4	10	0	1
Acute Composite	Claims	5	10	N/A	N/A
Chronic Composite	Claims	5	10	N/A	N/A
Total:		60.8	80	5	5
Cap applied to Bonus Categories (5%x total possible points):				4	4
Total with High Priority CEHRT Bonus:		68.8			

MIPS: Quality Performance Category Scoring Improvement

- Improvement scoring required in year 2, seeking comment on options
- Option 1: Hospital Value Based Purchasing Method
  - 1-9 points awarded for improvement
  - Use higher of achievement score or improvement score
- Option 2: MSSP Method
  - Up to 4 points awarded based on net quality improvement
  - Total number of significantly improved measures minus total number of significantly declined measures
- Option 3: MA 5-star method
  - Overall improvement score calculated
  - Number of significantly improved measures minus the number of significantly declined measures divided by the number of measures eligible for improvement
  - Measure must exist in both years and not have specifications change

MIPS: Resource Use Measures and Attribution

Measure	Attribution	Proposed Changes
Medicare Spending per Beneficiary	TIN providing plurality of Medicare Part B claims	• Remove specialty-adjustment • Evaluate observed to expected costs at the episode level • Measure is average of assigned ratios • 20 minimum cases
Total per Capita Cost	Two-step process: • TIN of PCP providing plurality of primary care services • TIN of Non-PCP providing plurality of primary care services	In the attribution include: • Transitional care management codes (99495 and 99496) and chronic care management code (99490), and • Exclude services billed under HCPCS codes 99304 – 99318 when the claim includes the POS 31 modifier (patients in skilled nursing facilities) • 20 minimum cases

Episode-based payment measures	• Acute condition: All MIPS eligible clinicians that bill at least 30% of inpatient E&M visits during trigger event; more than one clinician can be attributed
	• Procedural: MIPS eligible clinicians billing a part B claim with a trigger code during the trigger event
	  • Inpatient- inpatient stay triggering the episode plus day prior to admission
	  • Outpatient Method A- day before triggering claim- two days after triggering event
	  • Outpatient Method B- day of triggering event	

MIPS: Resource Use Episodes- Method A

Episode Name	2014 QRUR	Episode Name	2014 QRUR
Breast		**Genitourinary**	
1. Mastectomy for Breast Cancer	☑	Prostatectomy for Prostate Cancer	☑
Cardiovascular		**Infectious Disease**	
2. Acute Myocardial Infarction (AMI) without PCI/CABG	☑	Kidney and Urinary Tract Infection (UTI)	
3. Abdominal Aortic Aneurysm		**Metabolic**	
4. Thoracic Aortic Aneurysm		Osteoporosis	
5. Aortic/Mitral Valve Surgery	☑	**Neurology**	
6. Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation	☑	Parkinson Disease	
7. Atrial Fibrillation (AFib)/Flutter, Chronic		**Musculoskeletal**	
8. Coronary Artery Bypass Graft (CABG)	☑	Rheumatoid Arthritis	
9. Heart Failure, Acute Exacerbation	☑	Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based	☑
10. Heart Failure, Chronic		Hip Replacement or Repair	
11. Ischemic Heart Disease (IHD), Chronic		Knee Arthroplasty (Replacement)	
12. Pacemaker	☑	Spinal Fusion	
13. Percutaneous Cardiovascular Intervention (PCI):	☑	**Respiratory**	
Cerebrovascular		Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation	☑
14. Ischemic Stroke	☑	Asthma/Chronic Obstructive Pulmonary Disease (COPD), Chronic	
15. Carotid Endarterectomy	☑	Pneumonia, Community Acquired, Inpatient (IP)-Based	☑
Gastrointestinal		Pneumonia, Community Acquired, Outpatient (OP)-Based	
16.. Cholecystitis		Pulmonary Embolism, Acute	
17. Clostridium difficile Colitis		Upper Respiratory Infection, Acute, Simple	
18. Diverticulitis of Colon		**Vascular**	
		Deep Venous Thrombosis of Extremity, NOS, Acute	

MIPS: Resource Use Episodes- Method B

Episode Name	2014 QRUR
Gastrointestinal	
1. Cholecystectomy and Common Duct Exploration	☑
2. Colonoscopy and Biopsy	☑
3. Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia	☑
Infectious Disease	
4. Kidney and Urinary Tract Infection (UTI)	☑
Ophthalmology	
5. Lens and Cataract Procedures	☑
Musculoskeletal	
6. Hip Replacement or Repair	☑
7. Knee Arthroplasty (Replacement)	☑

MIPS: Resource Use Performance Category Scoring (10%)

- Benchmarks based on performance period
- Decile breaks used to assign points, up to 10 for each measure
- Average scores for all attributed measures

Measure	Measure Type	Number of Cases	Performance	Median Performance	Points	Total Possible
1	MSPB	20	15,000	13,000	4.0	10
2	Total Per Capita	21	12,000	10,000	4.2	10
3	Episode 1	22	15,000	18,000	5.8	10
4	Episode 2	10	11,000	9,000	Below Case Threshold	N/A
5	Episode 3	0	N/A	N/A	No Attributed Cases	N/A
6	Episode 4	45	7,000	10,000	8.3	10
Total Points					22.3	40

MIPS: Clinical Practice Improvement

- 60 points possible
  - High-weighted activities (11) = 20 points
  - Medium-weighted activities (83) = 10 points
- Exceptions
  - Small practice (less than 15) rural or health professional shortage area, non-patient facing report any 2 activities
  - Each activity worth 30 points (medium or high)
- CMS CPIA Study
  - Participants receive 60 points in recognition of burden associated with study
- Each activity must be performed for at least 90 days
- QCDRs
  - Can help meet activity criteria for multiple CPIAs
  - Must select and achieve each activity
  - Seek comment on allowing QCDRs to define specific CPIAs for specialty and non-patient-facing groups using the existing approval process

MIPS: CPIA High-Weight Activities

Subcategory	Activity (abbreviated)
Expanded Practice Access	Provide 24/7 access to MIPS eligible clinicians, eligible groups, or care teams for advice about urgent and emergent care
Population Management	Participation in a systematic anticoagulation program for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications
Population Management	60 percent or more of ambulatory care patients receiving warfarin are being managed by one or more clinical practice improvement activities: anticoagulant management service, decision support and clinical management tools, remote monitoring or telehealth, PST/PSM program
Population Management	For beneficiaries with diabetes 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least age, comorbidities, and risk for hypoglycemia; and b) Is reassessed at least annually
Population Management	Use of a Qualified Clinical Data Registry to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
Care Coordination	Participation in the CMS Transforming Clinical Practice Initiative.
Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan
Patient Safety Practice Assessment	Consultation of Prescription Drug Monitoring Program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than three days
Achieving Health Equity	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare
Integrated Behavioral and Mental Health	Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings.
Integrated Behavioral and Mental Health	Offer integrated behavioral needs to support behavioral health, dementia and chronic conditions using: evidence-based screening and treatment, registry to support care management

MIPS: CPIA- PCMH and APMS

- Patient Centered Medical Home or Specialty Recognition- 60 points
  - Nationally-recognized accredited programs
    - » Accreditation Association for Ambulatory Health Care
    - » National Committee for Quality Assurance (NCQA) PCMH Recognition
    - » NCQA Patient-Centered Specialty Recognition
    - » The Joint Commission Designation
    - » Utilization Review Accreditation Commission (URAC)
  - Request comments on how to give credit to groups when only a portion of the practice settings have received recognition
- APM Participation- 30 points
  - MIPS eligible Clinicians in an APM Entity group submit individual level data for remaining points
  - Scores aggregated and APM Entity provided one score

MIPS: CPIA Performance Category Scoring (15%)

Activity	Subcategory	Points	Relative Weight High = 2 Medium = 1	Points	Total Possible Points (fixed)
1	Expanded Practice Access	10	2	20	
2	Population Management	10	2	20	
3	Integrated Behavioral and Mental Health	10	1	10	
4	Achieving Health Equity	10	1	10	
Total Points				60	60

MIPS: Advancing Care Information (ACI)

- Formerly Meaningful Use
- Total Possible Score of 100 points
- Performance Period: Jan 1- Dec 31, 2017
  - Can submit partial year data and be scored
- Definitions
  - Certified health IT- technology and systems certified under ONC Health IT Certification Programs
  - Certified health IT module- a technology or function used independently of an EHR
  - Certified EHR Technology- technology used by MIPS eligible clinicians and participants in APMs
  - Meaningful User- a MIPS eligible clinician who possesses certified EHR technology, uses the functionality of certified EHR technology, and reports on applicable objectives and measures specified for the advancing care information performance category

MIPS: ACI CEHRT Version

- 2017- MIPS Eligible Clinician can use technology certified to 2015 or 2014 Edition
  - 2015 Edition: Stage 3 or modified Stage 2
  - Combination of 2015 and 2014 Edition: Stage 3 or modified Stage 2
  - 2014 edition: modified Stage 2
- 2018: Must use technology certified to 2015 Edition and report Stage 3 objectives and measures
- Reporting of objectives and measures at the group level

MIPS: ACI Performance Category Scoring (25%)

- Protecting Patient Health Information is a Must Pass Element
  - Failure to meet will result in 0 points for the entire performance category
- Base Score (50 Points)
  - Must submit for all required measures and objectives
  - Failure to submit any required objective results in a zero
  - Bonus Points
    - » 1pt for Optional Registry Reporting
- Performance Score (80 points)
  - 8 measures, 10 points each
  - Awarded points for 10% of performance score
- 100 possible total points
  - Can receive more than total points
- Reweighting ACI to 0% for certain clinicians
  - Hospital-based clinicians- more than 90% of care furnished in an inpatient hospital or ED
  - Hardship Exemption
  - NP, PA, CNS, CRNA- must submit application by March 31, 2018

MIPS: ACI Base Score (50 points)- Primary

Stage 3 Measures

Objective11	Measure	Description
Protect Patient Health Information	Security Risk Analysis **MUST PASS**	Conduct or review a security risk analysis in accordance with the requirements
Electronic Prescribing	ePrescribing	At least one permissible prescription written is queried for a drug formulary and transmitted electronically using CEHRT
Patient Electronic Access	Patient Access ★	For at least one unique patient : • Patient is provided timely access to view online, download, and transmit his or her health information; and • MIPS eligible clinician ensures the patient's health information is available for the using any application of the patient's choice meeting clinician API specifications
	Patient-Specific Education★	Must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access for at least one patient
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★	At least one unique patient actively engages with the EHR made accessible by 1. view, download or transmit to a third party their health information 2. access their health information through the use of an API 3. a combination of (1) and (2)
	Secure Messaging★	For at least one unique patient a secure message was sent using the electronic messaging function of CEHRT or in response to a secure message sent by the patient
	Patient-Generated Health Data★	Patient-generated health data or data from a non-clinical setting is incorporated into the CERTH for at least one unique patient

★contributes to performance score

MIPS: ACI Base Score (50 points)- Primary

Objective	Measure	Description
Health Information Exchange	Patient Care Record Exchange★	For at least one transition of care or referral, the clinician that transitions or refers their patient to another setting of care or health care provider • creates a summary of care record using certified EHR technology; and • electronically exchanges the summary of care record
	Request/Accept Patient Care Record★	For at least one transition of care or referral received or new patient encounter the clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document
	Clinical Information Reconciliation★	For at least one transition of care or referral received or new patient encounter the clinician performs clinical information reconciliation. 1. Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication 2. Medication allergy. Review of the patient's known medication allergies 3. Current Problem list. Review of the patient's current and active diagnoses
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)
	Syndromic Surveillance Reporting (Optional)	Active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting
	Electronic Case Reporting (Optional)	Active engagement with a public health agency to electronically submit case reporting of reportable conditions
	Public Health Registry Reporting (Optional)	active engagement with a public health agency to submit data to public health registries
	Clinical Data Registry Reporting (Optional)	Active engagement to submit data to a clinical data registry

MIPS: ACI Performance Category Scoring Example

Objective	Measure	Submitted	Performance	Points
Protect Patient Health Information	Security Risk Analysis **MUST PASS**	☑ Passed		
Electronic Prescribing	ePrescribing	☑		
Patient Electronic Access	Patient Access ★	☑	95%	9.5
	Patient-Specific Education★	☑	65%	6.5
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★	☑	33%	3.3
	Secure Messaging★	☑	31%	3.1
	Patient-Generated Health Data★	☑	25%	2.5
Health Information Exchange	Patient Care Record Exchange★	☑	21%	2.1
	Request/Accept Patient Care Record★	☑	38%	3.8
	Clinical Information Reconciliation★	☑	57%	5.7
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	☑		
	Syndromic Surveillance Reporting (Optional)			
	Electronic Case Reporting (Optional)			
	Public Health Registry Reporting (Optional)			
	Clinical Data Registry Reporting (Optional)	☑		+1
Points		50		.87.5

MIPS: Composite Performance Score

Performance Category	Points Awarded	Total Possible	2019 Payment Percentage	CPS Points
Quality	66.8	80	50%	41.75
Resources Use	22.3	40	10%	5.58
CPIA	60	60	15%	15
Advancing Care Information	87.5	100	25%	21.88
TOTAL				84.21

- Flexible Weighting
  - Only two scored quality measures, weight of category reduced by 1/5 (reduced to 40%, 30% if only one measure)
  - If a category does not have a score, the weight is redistributed to other categories
    - » No ACI or RU and 3 scored quality, reassign to quality; alternative redistribute proportionally
    - » No ACI or RU and less than 3 scored quality, redistribute proportionally
  - Scored on only one performance category, assigned a CPS score equal to performance threshold (0% adjustment factor)

MIPS: Eligible Clinicians Participating in MIPS APMs

- MIPS APM Entity Criteria
  - Participates in APM under agreement with CMS
  - Includes one or more MIPS eligible clinicians on a participant list
  - Bases payment incentives on performance on cost/utilization and quality
- MIPS APM Entity Characteristics
  - Could be a sole MIPS eligible clinician
  - Could include more than one unique TIN
  - Could split TINs- some MIPS eligible clinicians are in the APM while others are not
- APM Scoring Standard
  - Performance Period: January 1- December 31, 2017
    - » New APMs that begin after start of performance period: submit MIPS first year, use APM scoring standard in subsequent years
  - MIPS eligible clinicians must listed as a participant in the APM Entity on Dec 31 of performance year to qualify for APM Scoring Standard
  - CMS plans to establish an APM participant database

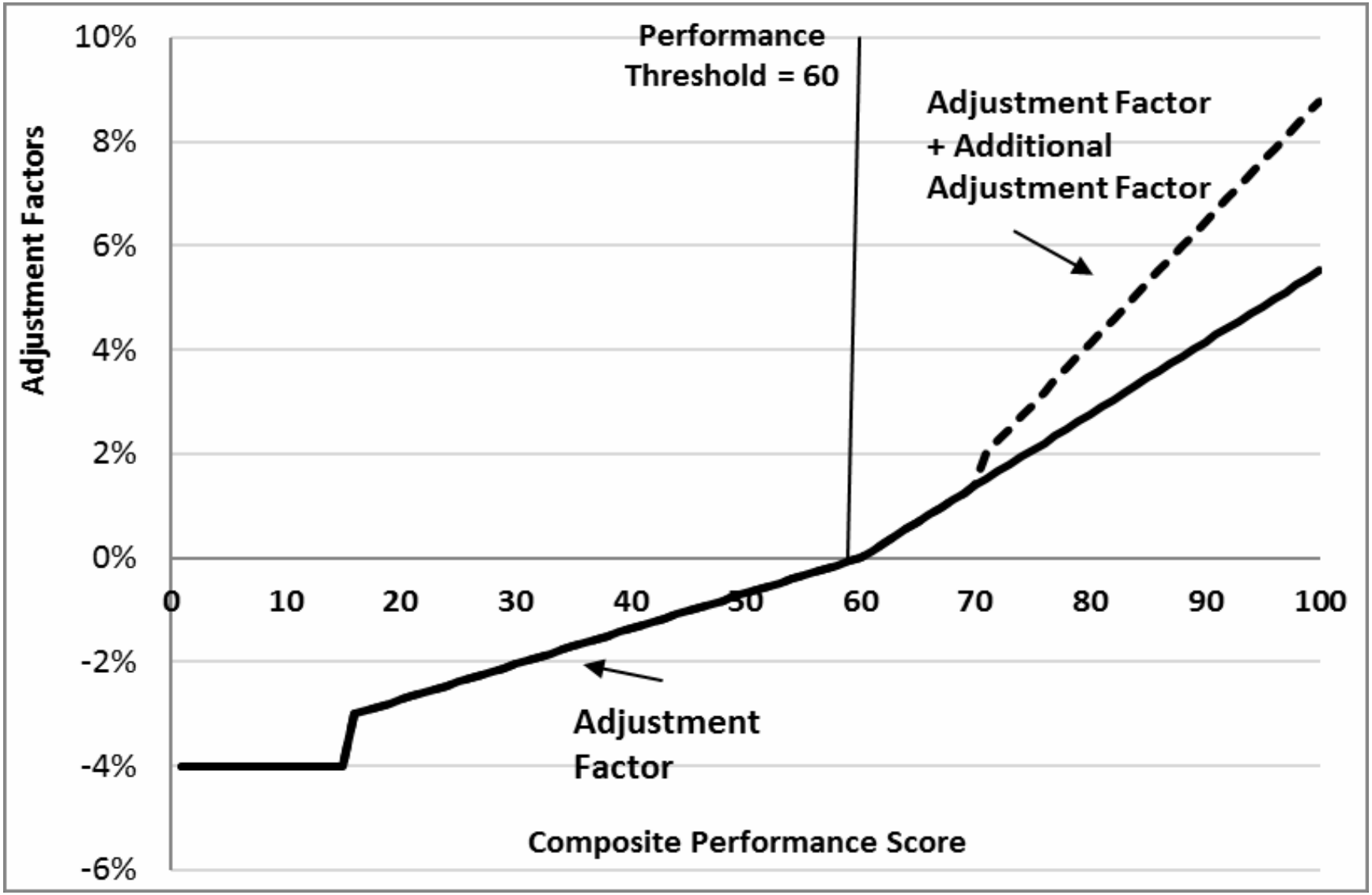
MIPS: APM Scoring Standard

Model	MIPS Performance Category	Alternative Payment Entity Data Submission Requirement	Performance Score	Category Weight
Shared Savings Program	Quality	Quality measures submitted Web Interface	MIPS quality performance category requirements and benchmarks will be used to determine the MIPS score at the ACO level.	50%
	Resource Use	Not assessed	N/A	N/A
	CPIA	Submit according to the MIPS requirements; CPIA performance assessed as a group through TINs associated with the ACO.	Weighted average of TINs in the APM Entity to produce ACO level score • All receive at least one-half total possible points	20%
	ACI	Submit according to the MIPS requirements; ACI performance assessed as a group through TINs associated with the ACO.	Weighted average of TINs in the APM Entity to produce ACO level score	30%
Next Generation ACO Model	Quality	Quality measures submitted Web Interface	MIPS quality performance category requirements and benchmarks will be used to determine the MIPS score at the ACO level.	50%
	Resource Use	Not assessed	N/A	N/A
	CPIA	All MIPS eligible clinicians in the APM Entity submit individual level data.	Average of individual eligible clinicians in the APM Entity to produce ACO level score • All receive at least one-half total possible points	20%
	ACI	All MIPS eligible clinicians in the APM Entity submit individual level data	Average of individual eligible clinicians in the APM Entity to produce ACO level score	30%
APMs other than the Shared Savings Program and Next Generation ACO Model	Quality	Not assessed submit quality measures required by APM		
	Resource Use	Not assessed		
	CPIA	All MIPs eligible clinicians in the APM Entity submit individual level data	Average of individual eligible clinicians in the APM Entity to produce APM Entity level score • All receive at least one-half total possible points	25%
	ACI	All MIPS eligible clinicians in the APM Entity submit individual level data	Average of individual eligible clinicians in the APM Entity to produce APM Entity level score	75%

MIPS: Payment Adjustment

- Adjustment factor applied to Part B payments
- TIN/NPI used for payment adjustment
  - Regardless of submitting at individual, group, or APM entity level
    - » CPS applied to all TIN/NPI under group or APM entity
  - Weighted average (based on percent of allowed charges) used when a clinician bills under multiple TINs
- Setting Performance Threshold for 2019 payment
  - Use past program data plus sensitivity analysis (CPIA) to model
  - Performance Threshold: Median CPS
  - Maximum Negative Adjustment: 4%
    - » CPS: 0- ¼ Performance Threshold
  - Positive Adjustment: 4% plus scaling factor up to 3.0X for budget neutrality
  - Additional Performance Threshold: 25th percentile of range of possible CPS above the average
    - » $500M available to apply an additional scaling factor up to 1.0X

MIPS: Payment Adjustment Example



MIPS: Feedback, Review and Corrections

- Feedback
  - July: Historical QRURs Available
  - MIPS data provided annually, first year data not available until 2018
  - CMS seeks comments on frequency and what data to provide
  - Targeted Review: Must submit request 60 days after close of data submission
- MIPS Adjustment Announcement
  - December 1, 2018
- Data Validation and Auditing
  - Selectively audit eligible clinicians yearly
    - » Must respond to requests in 10 business days
    - » Must provide primary source documents as requested
  - Establishes rules for recouping any over payments made as a result of inaccurate data
  - Clinicians must attest to accuracy and completeness of data

MIPS: Public Reporting on Physician Compare

- For each MIPS eligible clinician, composite score and performance by category
- Subsets of detailed information for each performance category
  - Quality: rates for measures determined suitable for public reporting (minimum sample size of 20)
  - Resource use: measures to be determined
  - CPIA: to be determined based on consumer and statistical testing
  - ACI: Indicator for clinicians successfully meeting this category
    - » Seeks comment on including a low performance indicator
- Aggregate information on range of scores
- Participation in Advanced APM with links to APM data

Advanced Alternative Payment Model (APM) Incentive

Track 2: 5% bonus for Advanced APMs

Alternative Payment Models (APM) are defined as:

- CMS Innovation Center model
- Medicare ACO
- Health Care Quality Demonstration
- Demo required by federal law
- Expanded medical home model

New programs TBD

2015 ▸ 2016 ▸ 2017 ▸ 2018 ▸ 2019 ▸ 2020 ▸ 2021 ▸ 2022 ▸ 2023 ▸ 2024 ▸ 2025 2026

Track 2

Measurement period

Advanced APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)

.75% update (2026➡)

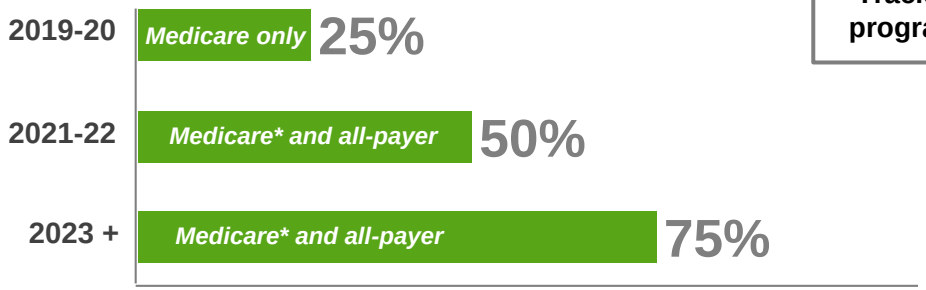
Greater update vs. Track 1 program

Advanced Alternative Payment Models (APM) Entities must:

1 | Submit MIPS comparable measures,

2 | Use certified EHR technology, and

3 | Bear more than "nominal" financial risk for losses



Threshold of payments in an Advanced APM

Inclusion in Advanced APMs triggers exclusion from MIPS.

- Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

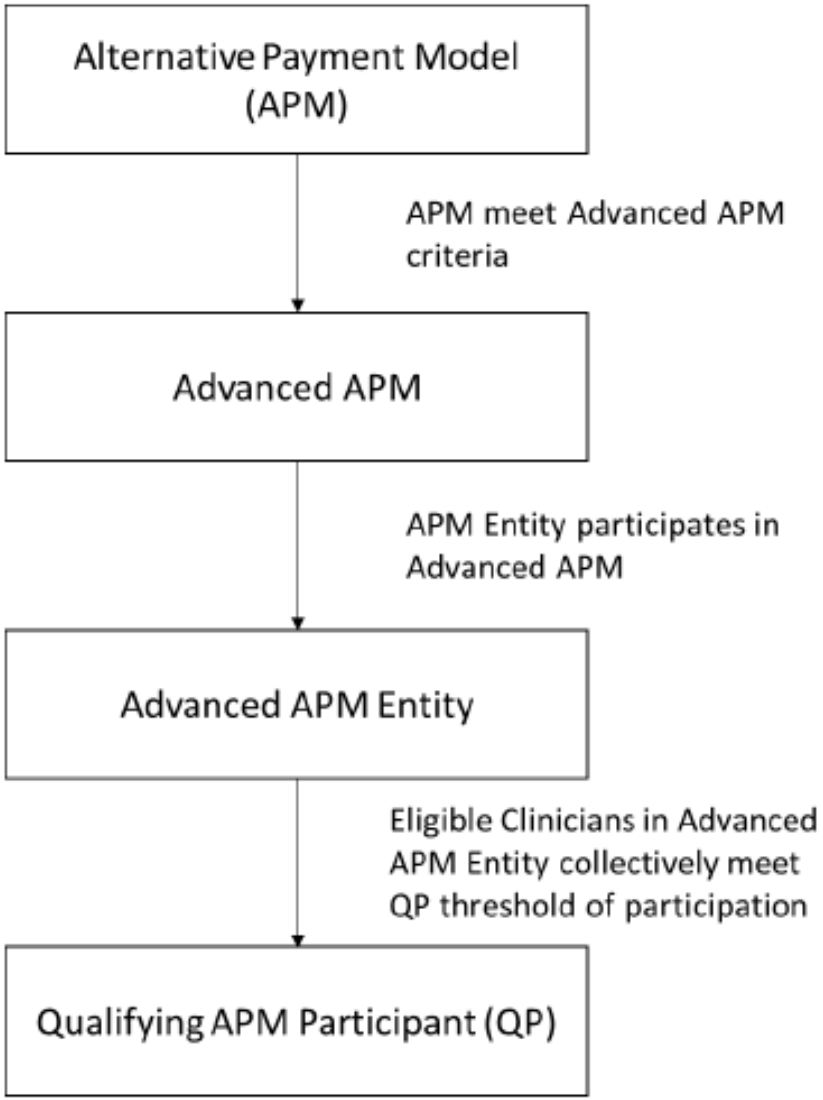
* Minimum of 25% of Medicare payments must be in APM, unless partial qualifying at 20% with no 5% bonus and a choice of MIPS

Advanced APM Principles and Goals

- Expand the opportunities for participation in APMs
- Maximize participation in current and future in Advanced (Medicare) APMs and Other Payer Advanced APMs.
- Create clear and attainable standards for incentives
- Promote the continued flexibility in the design of APMs
- Support multi-payer initiatives across the health care market

Advanced APM

FIGURE B: Program Overview



Qualified Participants (QPs) in Alternative Payment Model (APMs) get a lump sum 5% incentive payment equal to the prior year's payments for Part B professional services from 2019 – 2024 if the model and QPs meet certain criteria. Thereafter, QPs get a 0.75% update vs. 0.25%.

Advanced APMs Step 1: does the model qualify?

- Under MACRA, Medicare APMs include:
  - A model tested by the Innovation Center;
  - An ACO under the Medicare Shared Savings Program;
  - the Health Care Quality Demonstration Program; and
  - A demonstration required by Federal law if and only if:
    - » Not simply authorized; compulsory,
    - » Includes a demonstration “thesis” that is being evaluated, and
    - » Entities participate in the demonstration through an agreement with CMS or as specified by statute or region.

Advanced APMs Step 1: does the model qualify?

1. Payments are based on quality measures that are evidence-based, reliable and valid with at least 1 outcome measure including:
   - Quality measures applicable under MIPS;
   - Proposed annual list of MIPS quality measures;
   - Endorsed by a consensus-based entity;
   - Submitted in response to the MIPS Call for Quality Measures; or
   - Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.

2. At least 50% of eligible clinicians use certified EHR technology in 1st performance period (2017), increasing to 75% in 2nd performance period (2018)
   - Hospitals will be held to 75% from the start??
   - CEHRT definition to match MIPS; 2014 in 2017 and 2015 in 2018
   - The EHR Incentive Payment participation quality metric will count for Medicare Shared Savings Program

Advanced APMs Step 1: does the model qualify? (cont'd)

3. There is more than a nominal amount of risk for monetary losses (withhold, reduce or clawback payments):
   - **Total Risk** (maximum exposure) must be at least 4% of APM spending target
   - **Marginal Risk** (% of spending above APM benchmark or target price for which Advanced APM Entity is responsible – aka "sharing rate") must be at least 30%
   - **Minimum Loss Rate** (the amount spending can exceed APM benchmark or target price before Advanced APM entity bears loss) must be no more than 4%.
   - **Or**, is a full capitation risk arrangement

- Or, is a medical home model that is comparable to medical home models expanded under the Innovation Center
  - CMS proposes separate risk criteria

Medical Home Model: eligibility

- At minimum, a Medical Home Model must include:
  - Primary care or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
  - Empanelment of each patient to a primary clinician.
- In addition, it must have at least four of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (i.e. shared savings, population-based payments).

Medical Home Model: risk level

- Except when fewer than 50 eligible clinicians in the *parent* APM entity owner of a Medical Home Model then one or more of the following must apply:
  - Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;
  - Require direct payment by the APM Entity to the payer;
  - Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians, or
  - Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.
- The Entity must potentially owe or forego at least the following percent of their total Medicare Parts A/B revenue:
  - 2.5% in 2017,
  - 3% in 2018,
  - 4% in 2019, and
  - 5% in 2020 and later.

What's In?

Proposed Approved Advanced APM
Comprehensive ESRD Care (CEC) (LDO arrangement)
Comprehensive Primary Care Plus (CPC +)
Medicare Shared Savings Program tracks 2 & 3
Next Generation ACO Model and
Oncology Care Model (OCM) two-sided risk arrangement

What's Out?

Not Proposed as Advanced APM
Bundled Payment for Care Improvement Models 2/3/4
Comprehensive Care for Joint Replacement
Comprehensive ESRD Care (non- LDO arrangement)
Frontier Community Health Integration Program
Health Plan Innovation – Medicare Advantage Value-Based Insurance Design Model
Health Plan Innovation- Part D Enhanced Medication Therapy Management Model
Home Health Value-Based Purchasing Model
Independence at Home Demonstration

What's Out? (cont'd)

Not Proposed as Advanced APMs
Initiative to Reduce Preventable Hospitalizations Among Nursing Facility Residents - Phase 2
Intravenous Immune Globulin (IVIG) Demonstration
Maryland All-Payer Hospital Model
Medicare Part B Drugs Payment Model
Medicare Care Choices
Model Medicare Shared Savings Program - Track 1
Million Hearts: Cardiovascular Risk Reduction Model
Oncology Care Model one-sided risk arrangement

Advanced APM Step 2: are you in an Advanced APM Entity?

- "Eligible clinicians" in 2019-2020:
  - physicians,
  - physician assistants,
  - nurse practitioners,
  - clinical nurse specialists, and
  - certified registered nurse anesthetists
- Other "eligible clinicians" 2021 and beyond:
  - physical and occupational therapists,
  - qualified speech-language pathologists,
  - audiologists
  - certified nurse-midwives,
  - clinical social workers,
  - clinical psychologists, and
  - registered dieticians/nutrition professionals

Advanced APM Step 3: can you meet threshold score?

- **For 2019-2020:**
  - 25% of Medicare payments (Medicare Option)
  - NOTE: there is a patient count option for each timeframe as well
- **For 2021-2022:**
  - 50% of Medicare payments (Medicare Option) or
  - 50% of total payments, and at least 25% of Medicare payments (All-Payer Combination Option)
- **For 2023 and beyond**:
  - 75% of Medicare payments (Medicare Option) or
  - 75% of total payments, and at least 25% of Medicare payments (All-Payer Combination Option)
- Medicare Advantage plans do not qualify as Medicare; they will be considered in the All-Payer Combination Option
- Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

Partial qualifying APM participants

- Clinicians who meet somewhat lower payment thresholds than those for qualifying APM participants can be designated as partial QPs:
  - **For 2019-2020**,
    - » 20% of Medicare payments
  - **For 2021-2022**,
    - » 40% of Medicare payments or
    - » 40% of total payments (and at least 20% of Medicare payments)
  - **For 2023 and beyond**:
    - » 50% of Medicare payments or
    - » 50% of total payments (and at least 20% of Medicare payments)

CMS Tables 33 and 35- QP Payment Amount and Patient Thresholds--Medicare Option

Medicare Option - Payment Amount Method						
Payment Year	2019	2020	2021	2022	2023	2024 and later
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

All-Payer Combination Option - Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Medicare Threshold Option - Patient Count Method						
Payment Year	2019	2020	2021	2022	2023	2024 and later
QP Patient Count Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	35%	35%

All-Payer Combination Option - Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial Payment Amount Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

CMS TABLE 38 & 39: QP Payment Amount and Patient Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

All-Payer Combination Option – Patient Count Method										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Patient Count Threshold	N/A	N/A	35%	25%	35%	20%	50%	35%	50%	35%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	25%	35%	25%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Other Payer Advanced APM

- Payment arrangements with non-Medicare payer (Other Payer APM) can become an Other Payer Advanced APM if the arrangement meets three criteria:
  - Certified Electronic Health Record technology (CEHRT) is used;
  - Quality measures comparable to measures under the MIPS; and
  - The APM Entity either:
    - » bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or
    - » for beneficiaries under title XIX, is in a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.
- Other Payer APMs include payment arrangements under any payer other than traditional Medicare FFS.
- Medicare Advantage and other Medicare-funded private plans are categorized as Other Payer APMs.

Other Payer Advanced APM: risk standard

- Other Payer Advanced APM must, if actual aggregate expenditures exceed expected aggregate expenditures in a specified performance period:
  - Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;
  - Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or
  - Require direct payment by the APM Entity to the payer.
- The risk arrangement must have:
  - A marginal risk rate of at least 30%, and
  - Total potential risk of at least 4% of expected expenditures; or
  - Capitation.

Medicaid Medical Home Model: eligibility

- Medicaid Medical Home Model must have the following two minimum elements:
  - model participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services, and
  - empanelment of each patient to a primary clinician.
- And, it must have at least 4 of the following elements:
  - Planned chronic and preventive care.
  - Patient access and continuity.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings, population-based payments).

Medicaid Medical Home Model: risk standard

- Except when fewer than 50 eligible clinicians in the *parent* APM entity owner of a Medicaid Medical Home Model then one or more of the following must apply:
  - Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;
  - Require direct payment by the APM Entity to the payer;
  - Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians, or
  - Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.
- Entity must potentially owe or forego:
  - In 2019, 4% of the APM Entity's revenue under the payer; or
  - In 2020 and later, 5% of the APM Entity's revenue under the payer.

Submission of Information for Other Payer Advanced APM Determination and Threshold Score Calculation

- Entities and/or eligible clinicians must submit certain information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria and to calculate Threshold Scores for a QP determination under the All-Payer Combination Option:
  - By date and in a manner specified—the following data must be submitted—
    - » Payment arrangement information—financial risk arrangements, use of certified EHR technology, and payment tied to quality; and
    - » The amounts of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement, and the total number of patients furnished any service through the payer.
- Payers must attest to the accuracy of submitted information and contracts may be subject to audit.
- CMS will determine in advance if Medicaid Medical Home Models and Medicaid APMs exist.

Qualified Professional (QP) and Partial QP Test

- Determinations made after each QP performance period, which is the full calendar year aligning with MIPS (e.g., 2017 for 2019 payment year).
- Calculations at the aggregate level using data for *all* eligible clinicians participating in an Advanced APM Entity as of December 31 of the QP performance period.
  - Will check at the eligible clinician level if participating in more than one APM that fails– to combine payments and patient counts
- APM participant lists used unless no participant list, in which case the affiliates list may be used
- Medicare option will be calculated first then the All-Payer combination Option
- Higher of payments or patient count will be used
- CMS will notify each Entity and clinician and post on web
- If Partial QP, each Entity will decide MIPS participation during the QP except MSSP at the TIN level

Threshold score calculation: attribution

- An “attributed beneficiary” is one attributed to the Advanced APM Entity on the latest available list of such beneficiaries during the QP performance period, with attribution following that entity’s specific attribution rules.

- “Attribution-eligible beneficiary” beneficiary would be one who:
  - Is not enrolled in Medicare Advantage or a Medicare cost plan,
  - Does not have Medicare as a secondary payer,
  - Is enrolled in both Parts A and B,
  - Is at least 18 years of age,
  - Is a United States resident, and
  - Has at least one evaluation and management service claim for one or more eligible clinicians within an APM Entity at some point within the QP performance period.

Threshold score calculation: numerator/denominator

Medicare option:

- **Numerator-** is payments [or # of unique attributed beneficiaries*] made *through* an Advanced APM Entity to an eligible clinician from Medicare.**
- **Denominator-** is *total* payments [or # of attribution eligible beneficiaries] made to eligible clinician from Medicare.

All-payer Combination Option:

- **Numerator-** is payments [or # of unique attributed beneficiaries] made *through* an Advanced APM Entity to an eligible clinician that combine such payments from Medicare, commercial, and in certain cases Medicaid payers.
- **Denominator-** is *total* payments [or # attribution eligible beneficiaries] made to eligible clinician that combine payments from Medicare, commercial, and in certain cases Medicaid payers.

*Depending on whether calculating the % payment or patient count
** for the numerator only services provided during the episode would count, but for the denominator it is all service during the QP performance period

Incentive Payment

- Incentive Payment to eligible clinicians that achieve QP status for the year (2019- 2024) equal to 5% of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding calendar year across all billing TINs associated with the QP's NPI.
- Three months of claims run out will be included.
- Lump some payments likely paid 6-months into the year.
- Excludes the MIPS, VM, MU and PQRS payment adjustments when calculating the estimated aggregate payment amount for covered professional services
- Excludes financial risk payments such as shared savings payments or net reconciliation payments, when calculating the estimated aggregate payment amount
- Will not affect actual expenditures under an APM

Supplemental Service Payments

- Inclusion of supplemental service payments will considered on a case-by-case.
- If payments are for covered services that are *in lieu* of services reimbursed under the PFS, those payments would included in the APM Incentive Payment amounts.
- Incentive Payment amount will be included if it meets all of the following 4 criteria:
  - Payment is for services that constitute physician services authorized under section 1832(a) of the Act and defined under section 1861(s) of the Act.
  - Payment is made for only Part B services under the first criterion above, that is, payment is not for a mix of Part A and Part B services.
  - Payment is directly attributable to services furnished to an individual beneficiary.
  - Payment is directly attributable to an eligible clinician.

Physician Focused Payment Models (PFPM)

- Definition
  - Medicare as a payor, can include other payors
  - Includes APM entities (i.e. physician group practices or individual physicians)
  - Targets quality and cost of physician services
- PTAC
  - Physician-focused payment technical advisory committee
  - Review and may recommendations to the Secretary regarding PFPMs that are APMs or Advanced APMs
- Model Review Criteria
  - Payment Incentives- volume over value, flexibility, quality and cost, payment methodology, scope, ability to be evaluated
  - Care delivery improvements- integration and care coordination across providers and settings, patient choice, patient safety, patient engagement
  - Information enhancements- use of health IT to inform care

MACRA possible To Do List:

- MACRA assessment
- Build legal structure (PHO)
- Alter governance structure (PFAC, 75% test)
- New HR strategy (teams, compensation structure, willingness to use CEHRT)
- Enhance adequacy of
  - physician,
  - post-acute care and
  - community network
- Build primary care network
- Get all sites on CEHRT
- Alter private contracts as they turn over
- Plan for Certificate of Need for any additional sites/services
- Seek certification for risk bearing entity at state level

Important Links

- Premier detailed summary
- Premier's Flash Update
- Proposed rule
- CMS press release
- HHS blog on proposed rule
- CMS blog
- CMS fact sheets and other information on MACRA

Transforming Healthcare TOGETHER

Appendix

MIPS: ACI Base Score (50 points)- Alternate Proposal

Objective	Measures
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	ePrescribing
Clinical Decision Support (CDS)	Clinical Decision Support (CDS) Interventions *Implement 3 CDS interventions related to 3 CQMs*
	Drug Interaction and Drug-Allergy Checks *Enabled and implemented functionality for drug-drug and drug-allergy checks*
Computerized Provider Order Entry (CPOE)	Medication Orders *At least on medication order created using CPOE*
	Laboratory Orders *At least one lab order created using CPOE*
	Diagnostic Imaging Orders *At least one imaging order created using CPOE*
Patient Electronic Access	Patient Access★
	Patient-Specific Education★
Coordination of Care Through Patient Engagement	View, Download or Transmit (VDT) ★
	Secure Messaging★
	Patient-Generated Health Data★
Health Information Exchange	Patient Care Record Exchange★
	Request/Accept Patient Care Record★
	Clinical Information Reconciliation★
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting
	Syndromic Surveillance Reporting (Optional)
	Electronic Case Reporting (Optional)
	Public Health Registry Reporting (Optional)
	Clinical Data Registry Reporting (Optional)

MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Practice Size

Practice Size	Eligible Clinicians	Physician Fee Schedule Allowed Charges (mil)	Percent Eligible Clinicians with Negative Adjustment	Percent Eligible Clinicians with Positive Adjustment	Aggregate Impact Negative Adjustment (mil)	Aggregate Impact Positive Adjustment (mil)
Solo	102,788	$12,458	87.0%	12.9%	-$300	$105
2-9	123,695	$18,697	69.9%	29.8%	-$279	$295
10-24	81,207	$9,934	59.4%	40.3%	-$101	$164
25-99	147,976	$12,868	44.9%	54.5%	-$95	$230
100+	305,676	$18.648	18.3%	81.3%	-$57	$539
Overall	761,342	$72,606	45.5%	54.1%	-$833	$1,333

Projected Number of Clinicians Ineligible for or Excluded from MIPS in CY 2017, by Reason*

Reason for Exclusion	Number of Physicians and Other Professionals	Allowed Charges (mil)
All	524,002 – 583,344	$13,909 - $19,561
Qualifying APM Participants**	30,658 lower bound 90,000 upper bound	$2,919 - $8,517
Ineligible Specialties***	187,990	$9,159
Newly-enrolled clinicians****	79,739	$1,137
Low-volume clinicians*****	225,615	$694

*Estimates prepared using available 2014 data.
** QPs have at least 25 percent of their Medicare payments or Medicare patients through an Advanced APM. The upper bound estimate for QPs also reflects that a small number of Advanced APM participants may be Partial QPs that opt to be excluded from MIPS. For MIPS Year 1, Partial QPs are APM participants that have at least 20%, but less than 25%, of their Medicare Part B payments for covered professional services through an Advanced APM Entity, or at least 10%, but less than 20%, of their Medicare patients served through an Advanced APM Entity
***Section 1848(q)(1)(C) of the Act defines a MIPS eligible clinician for payment years 1 and 2 as a physician, physician's assistant, nurse practitioner, or clinical nurse anesthetist, or a group that includes such clinicians.(See Section II.E.1 for further details) Our estimates of ineligible specialties count specialties not listed as eligible specialties in the Act for payment year 1 or 2: Audiologists, Certified Nurse Midwives, Clinical Psychologists/Counselors, Clinical Social Workers, Physical/Occupational Therapists, and Registered Dieticians/Nutritionists.
****Newly enrolled Medicare clinicians have allowable charges for Medicare Part B for in Calendar Year (CY) 2014 but the NPI does not have allowable charges in CY 2013.
*****Low-volume clinicians have less than $10,000 in Medicare Allowable charges and fewer than 100 Medicare patients

MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty: Mid-point Estimate

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Negative Payment Adjustment	Percent with Positive Payment Adjustment	Aggregate Impact Negative Payment Adjustment (mil)	Aggregate Impact Positive Adjustment (mil)
All	761,342	$72,606	45.5%	54.1%	-$833	$1,333
Allergy/Immunology	3,031	$199	57.1%	42.6%	-$4	$3
Anesthesiology	34,233	$1,904	47.4%	52.2%	-$25	$29
Cardiology	29,176	$5,791	37.5%	62.1%	-$35	$127
Clinical Nurse Specialists	1,681	$57	54.7%	44.9%	-$1	$1
Colon/Rectal Surgery	1,244	$136	40.0%	59.7%	-$1	$3
Critical Care	2,550	$265	46.3%	53.5%	-$4	$4
Dentist	915	$26	68.9%	30.1%	-$1	$0
Dermatology	10,317	$2,824	42.4%	57.6%	-$21	$92
Emergency Medicine	41,728	$2,626	35.4%	64%	-$19	$53
Endocrinology	5,401	$445	32.6%	67.3%	-$3	$10
Family Practice	79,541	$5,666	40.2%	59.5%	-$60	$103
Gastroenterology	12,608	$1,639	38.3%	61.5%	-$16	$34
General Practice	3,598	$273	69.4%	30.3%	-$5	$2
General Surgery	20,387	$1,926	45.5%	54.2%	-$24	$35
Geriatrics	3,790	$447	48.3%	51.6%	-$7	$4

MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty: Mid-point Estimate

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Negative Payment Adjustment	Percent with Positive Payment Adjustment	Aggregate Impact Negative Payment Adjustment (mil)	Aggregate Impact Positive Adjustment (mil)
Hand Surgery	1,779	$230	48.7%	51.1%	-$3	$4
Infectious Diseases	5,544	$644	42.9%	56.9%	-$12	$9
Internal Medicine	89,257	$9,327	40.3%	59.4%	-$4	$6
Interventional Radiology	1,780	$337	40.4%	59.2%	-$4	$6
Nephrology	8,497	$2,065	41.6%	58.0%	-$19	$37
Neurology	13,000	$1,248	40.6%	59.2%	-$15	$24
Neurosurgery	4,489	$689	43.8%	55.6%	-$8	$12
Nuclear Medicine	626	$100	44.2%	55.0%	-$2	$2
Nurse Anesthetist	31,737	$826	51.1%	48.4%	-$14	$9
Nurse Practitioner	50,764	$1,626	37.7%	62.1%	-$13	$24
Obstetrics/Gynecology	21,650	$538	38.8%	61.1%	-$8	$10
Oncology/Hematology	11,705	$1,706	37.5%	62.1%	-$13	$24
Ophthalmology	17,259	$5,060	44.8%	54.7%	-$43	$114
Optometry	18,394	$945	79.7%	20.2%	-$21	$10
Oral/Maxillofacial Surgery	200	$7	55.0%	45.5%	$0	$0

MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty: Mid-point Estimate

Provider Type	Number of Physicians and Other Clinicians	Allowed Charges (mil)	Percent with Negative Payment Adjustment	Percent with Positive Payment Adjustment	Aggregate Impact Negative Payment Adjustment (mil)	Aggregate Impact Positive Adjustment (mil)
Orthopedic Surgery	20,277	$3,254	46.4%	53.3%	-$33	$63
Other MD/DO	10,674	$1,117	42.9%	56.7%	-$15	$20
Otolaryngology	8,211	$1,015	47.4%	52.3%	-$13	$18
Pathology	7,302	$593	43.3%	56.7%	-$9	$10
Pediatrics	4,589	$55	20.6%	79.3%	-$1	$1
Physical Medicine	7,295	$918	57.9%	41.9%	-$17	$12
Physician Assistant	43,994	$1,212	32.5%	67.1%	-$13	$26
Plastic Surgery	3,691	$287	65.4%	34.5%	-$7	$4
Podiatry	15,310	$1,882	78.0%	21.8%	-$46	$14
Psychiatry	20,854	$1,143	68.8%	31.1%	-$29	$8
Pulmonary Disease	10,493	$1,655	41.9%	57.8%	-$20	$26
Radiation Oncology	4,239	$1,513	44.2%	55.4%	-$16	$27
Radiology	34,998	$4,165	49.2%	50.4%	-$1	$1
Registered Nurse	1,942	$58	49.3%	50.4%	-$1	$1
Rheumatology	4,274	$495	32.3%	67.6%	-$3	$13
Thoracic/Cardiac Surgery	3,688	$596	37.7%	61.8%	-$5	$11
Urology	8,814	$1,586	40.5%	59.2%	-$13	$31
Vascular Surgery	3,244	$906	42.4%	57.2%	-$10	$18