MACRA, MIPS, QPP, and APMs.

Implication for Hospital Practice.

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March 25, 2017

OU Medicine

Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

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Objectives

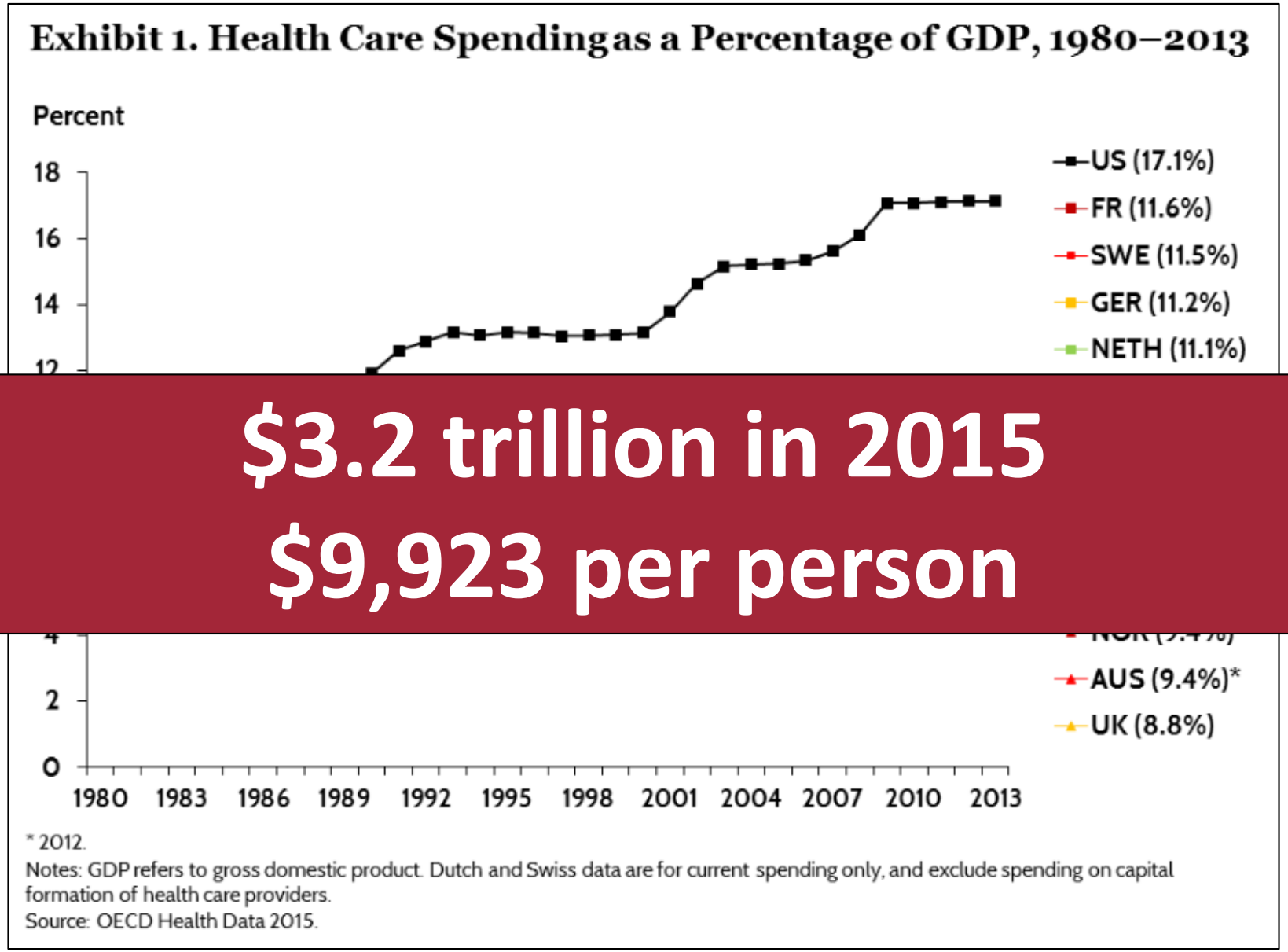
- Explain the drivers promoting change in payment methods
- Summarize current programs designed to move to value-based payment for healthcare
- Describe the role of internal medicine as systems become accountable for costs and quality of patient outcomes

Drivers of Payment Reform

- We have a payment system that has rewarded more care, regardless of the value (or quality) of that care.

- Payment models have not promoted coordination of care across settings

Health spending grew 4.8 percent in 2016, slightly less than the year before when it rose 5.8 percent. However, don't expect the expenditures to stall for long, the report found. They could account for nearly 20 percent of U.S. spending by 2025.



$3.2 trillion in 2015

$9,923 per person

http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

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Where do we spend the money?

- Hospitals - $971 billion in 2014 (a 4.1% increase)
- Physicians and clinical services - $604 billion in 2014 (a 4.6% increase)

	Spending*	Increase
Other professional services	$84.4	5.2%
Dental services	$113.5	2.8%
Home health services	$83.2	4.8%
Nursing care facilities	$155.6	3.6%
Prescription drugs	$297.7	12.2%

*in billions

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

- Top 2*
- Middle
- Bottom 2*

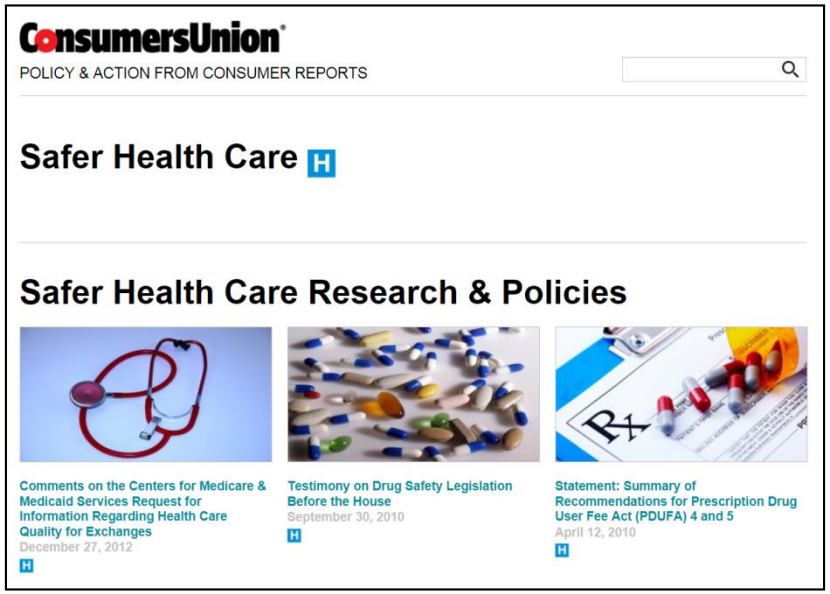
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

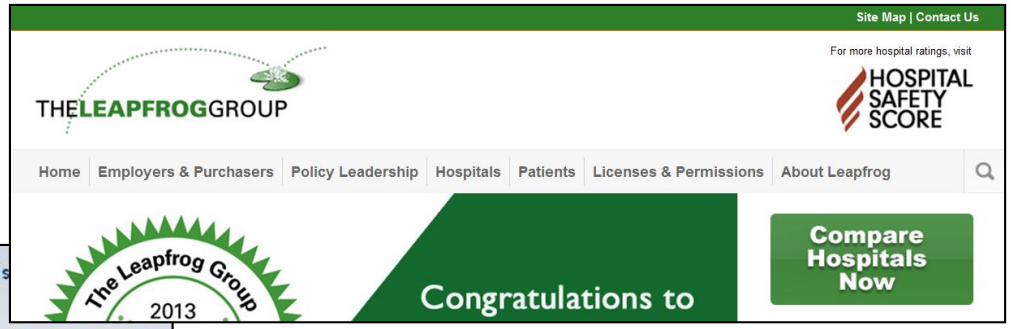
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

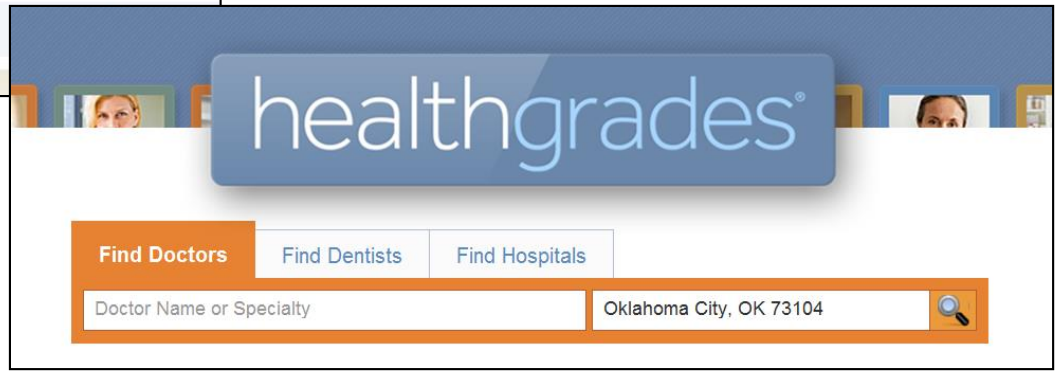
Consumers are demanding transparency!

- Consumer groups are demanding transparency – particularly about quality and costs of care



Transparency!





Healthcare quality is in the public domain for most settings of care!

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Congress Reacts

- When consumer groups have a consistent message, legislators respond…
  - The Medicare Program and other agencies then are required to adopt standardized measures that reflect the quality of medical practice
- Multiple laws passed since 2003 require the Secretary of HHS to measure, publicly report, and to adjust payment based on quality of care

Three events that have accelerated the move to value……

Affordable Care Act (2010) Accelerates the Move

Move to "Value"

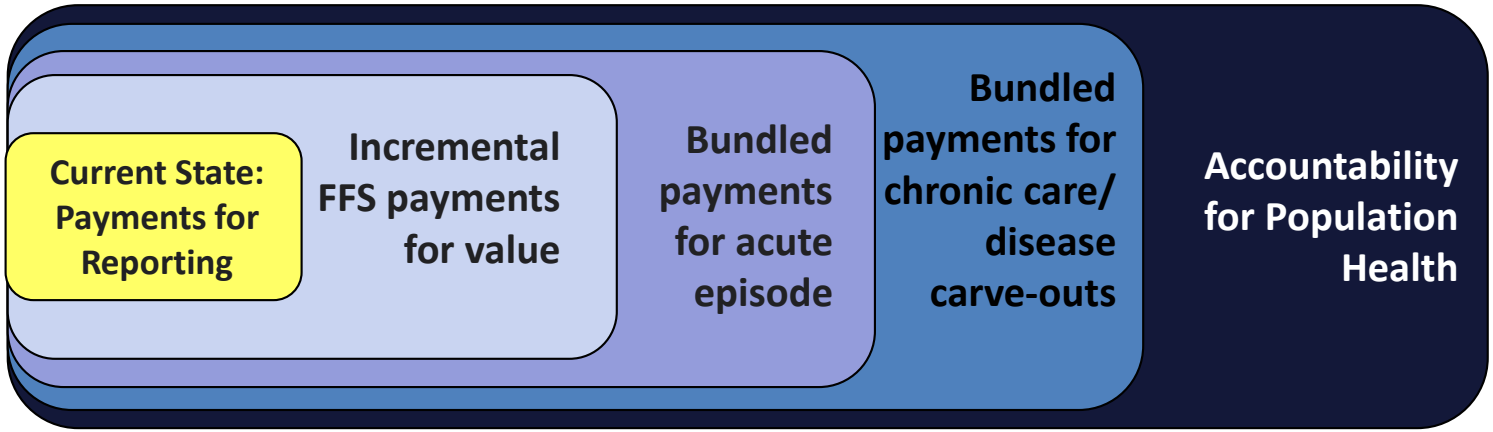
Value = Quality (and Service)/Costs

Goal: We want the highest quality of care (and service) at the lowest costs.

Range of Models in Existence or Development

Increasing assumed risk by provider

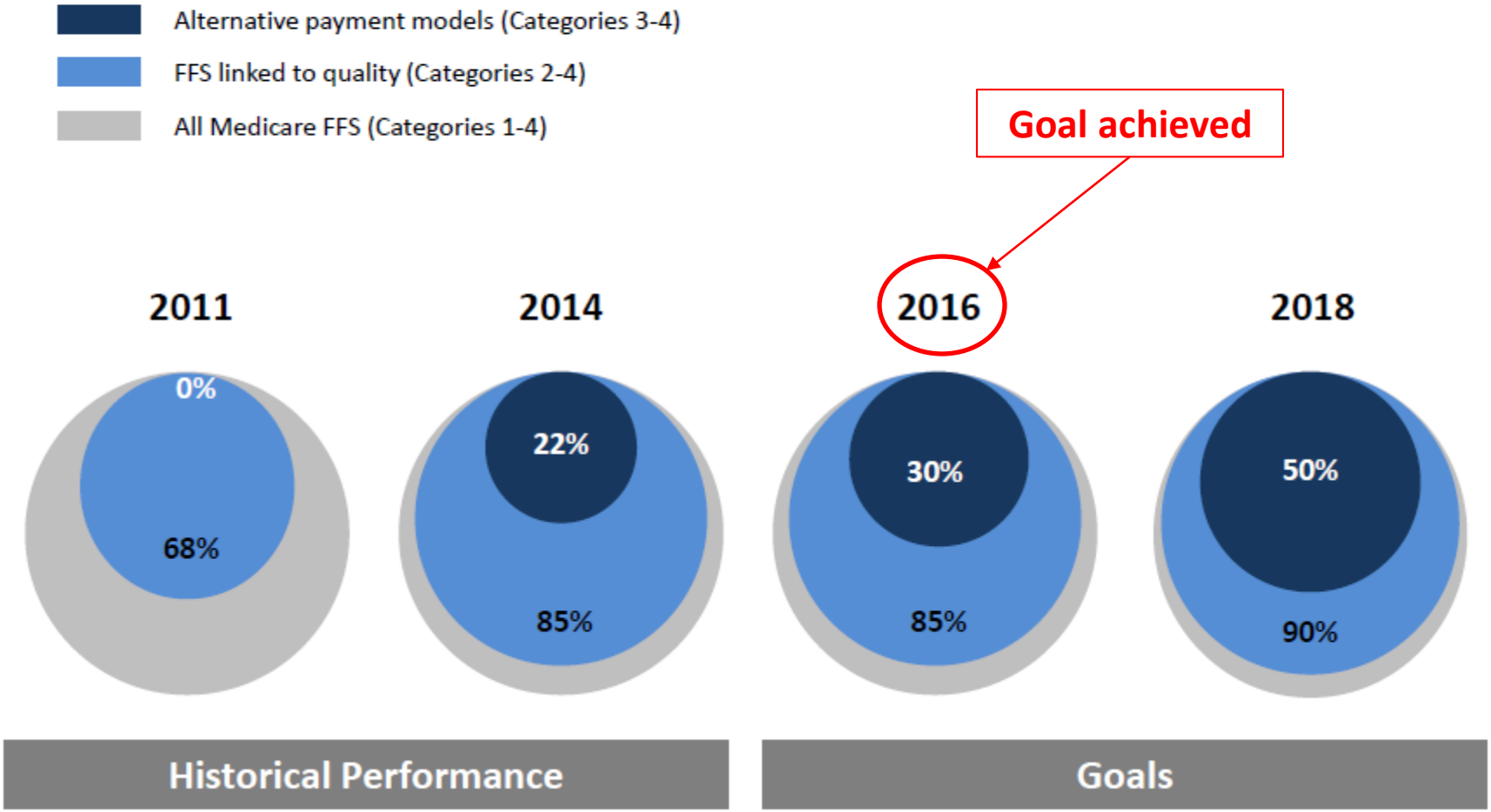
Increasing coordination/integration required



From…. ..get paid more for doing more

To…. ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost

Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



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The new alphabet soup…….

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

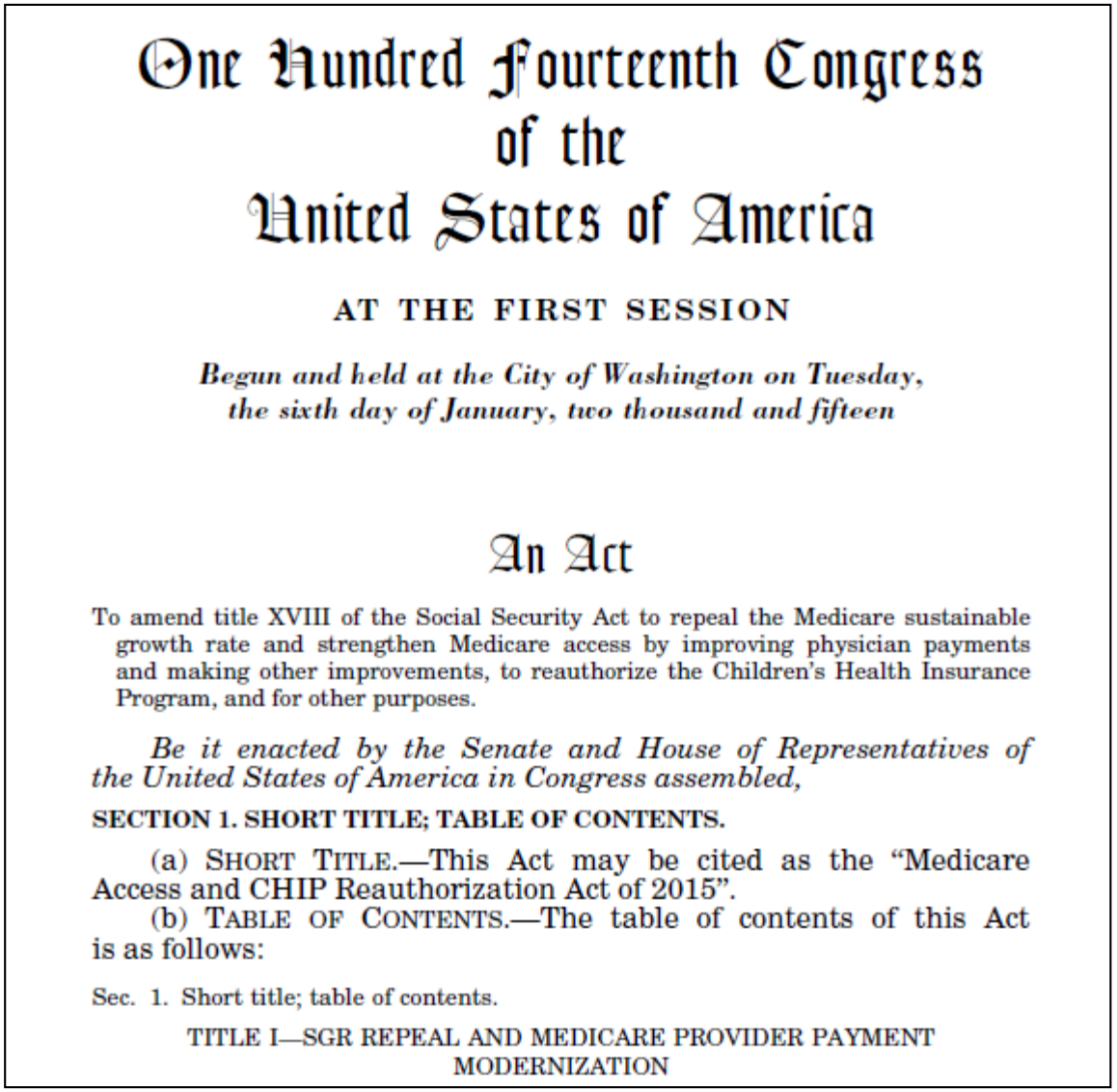
IF  **>** 

Overall physician costs **Target Medicare expenditures**

Physician payments cut across the board

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)



One Hundred Fourteenth Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and fifteen

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Access and CHIP Reauthorization Act of 2015".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

Republican controlled Senate and House:

- **Senate vote: 92 yea; 8 nay**
- **House vote: 392 yea; 37 nay**

House sponsor: Michael C. Burgess, MD [R - Texas]

Repealed the SGR!

Very bipartisan!

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf

MACRA Final Rule released on October 14, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 414 and 495

[CMS-5517-FC]

RIN 0938-AS69

Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals

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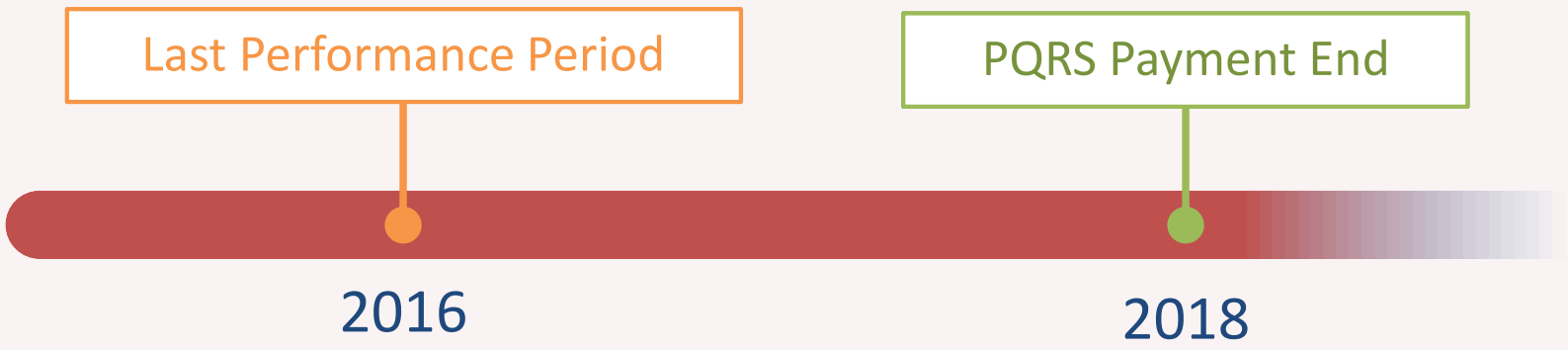
Available at: https://qpp.cms.gov/docs/CMS-5517-FC.pdf

MACRA moves Medicare Part B clinicians to a performance-based payment system

What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

Legacy Program Phase Out



Who's in or out?

Who's in?

- Physicians*
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists

Who's excluded?

- If 2017 is your first year of participation in Medicare
- You have less than or equal to $30,000 in Medicare Part B allowed charges for the year
- You care for less than or equal to 100 Medicare patients during the year

*Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

TITLE I—SGR Repeal and Medicare Provider Payment Modernization – What happens in 2017?

Quality Payment Program (QPP)

Advanced Alternate Payment Mechanisms (APM)

- "Substantial portion" of revenues from "approved" alternate payment models
  - 5% bonus each year from 2019-2024
  - 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System (MIPS)†

- Providers receive a score of 0-100
- Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  - Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap).

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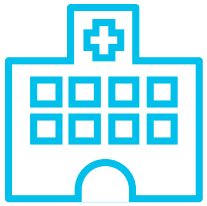
†Performance scores will be posted to Physician Compare website.

Pick Your Pace for Participation for the Transition Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

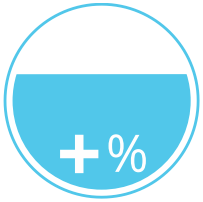
MIPS

Test

Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year



Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

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MIPS: Choosing to Test for 2017

Submit Something

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: *"What is a minimum amount of data?"*

1
Quality
Measure

OR

1
Improvement
Activity

OR

4 or 5
Required
Advancing
Care
Information
Measures

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Merit-based Incentive Payment System (MIPS)*

- **Quality Performance**
  - Replaces the Physician Quality Reporting System (PQRS) and some components of the Value-Based Modifier
- **Resource Use**
  - Replaces the cost component of the VBM
- **Clinical Practice Improvement Activities (CPIA) - new**
- **Advancing Care Information**
  - Replaces the Meaningful Use (MU) program
  - a particular emphasis on interoperability and information exchange

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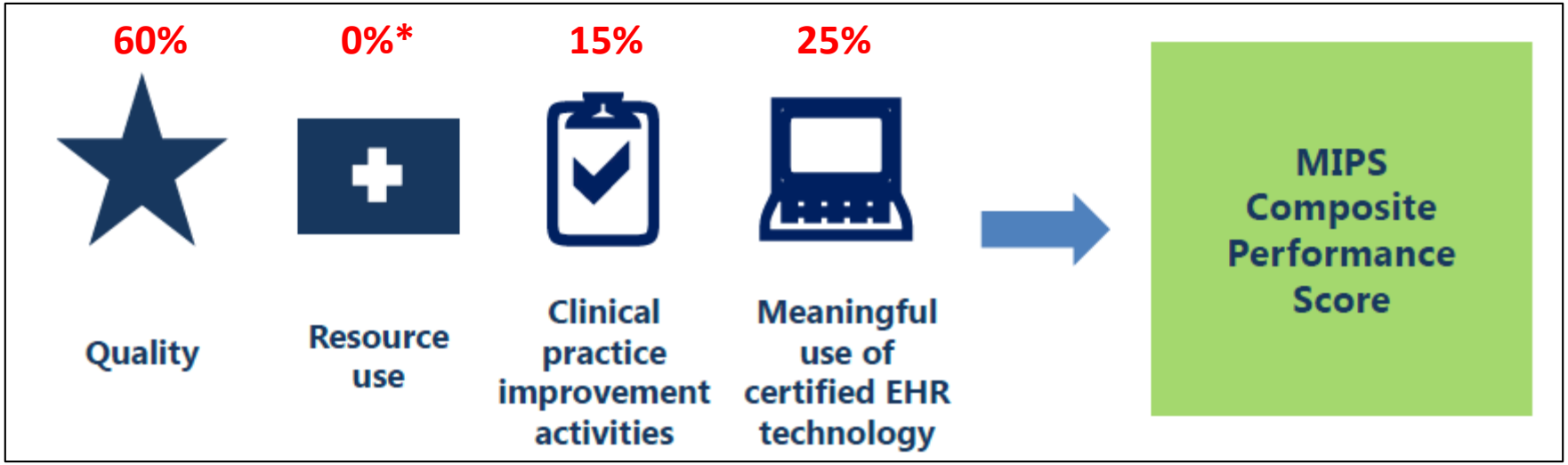
*Does include the Group Practice Reporting Option. Performance in 2017 will impact 2019 payment.

Merit-based Incentive Payment System (MIPS)



First performance year is CY 2017 to adjust payment in CY 2019.

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*Reduced to 0% for the 2017 "transition year" only. By statute, must go up to 30% for payment year CY 2021.

Shifting Performance Weights

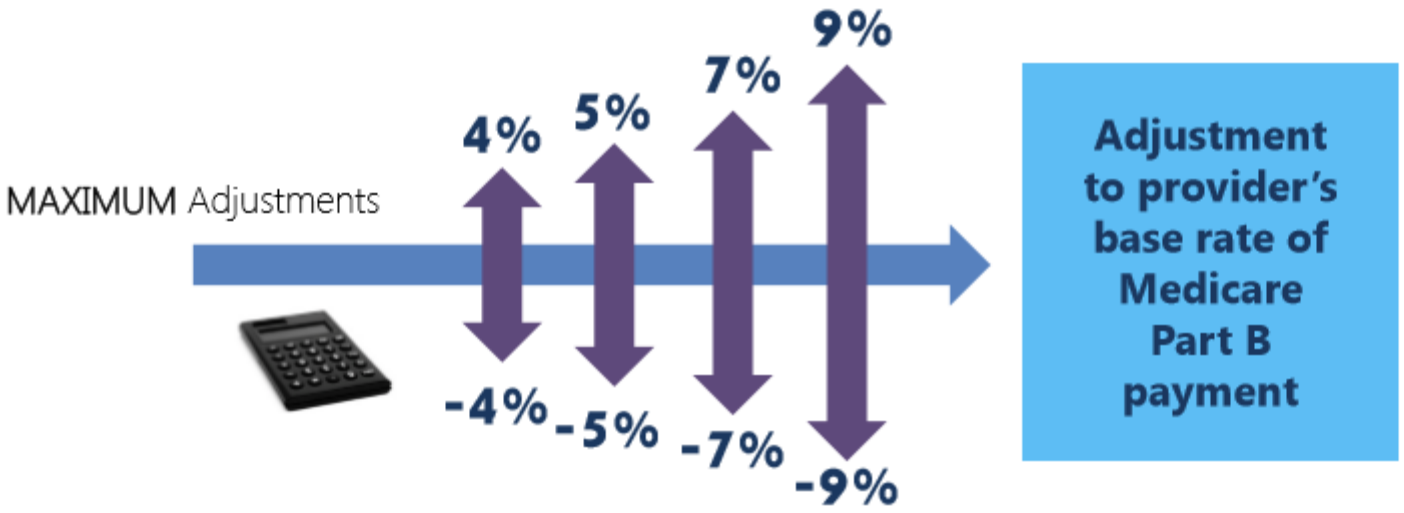
PERFORMANCE CATEGORY	2017	2018	2019
Quality	60%	50%	30%
Cost	0%	10%	30%
Advancing Care Information	25%	25%	25%
Improvement Activities	15%	15%	15%

Performance in each category is weighted and used to calculate a final score (0-100).

Remember: Performance during a calendar year affects payment two years subsequently.

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



MIPS Scoring for Quality

(60% of Final Score in Transition Year)

Select 6 of the approximately 300 available quality measures (minimum of 90 days)

- Or a specialty set
- Or CMS Web Interface measures
- Readmission measure is included for group reporting with groups with at least 16 clinicians and sufficient cases

Clinicians receive 3 to 10 points on each quality measure based on performance against benchmarks

Failure to submit performance data for a measure = 0 points

Bonus points are available

Quality Payment Program

Learn About the Program | Explore Measures | Education & Tools

Program Performance | Quality Measures | Advancing Care Information | Improvement Activities

Quality Measures

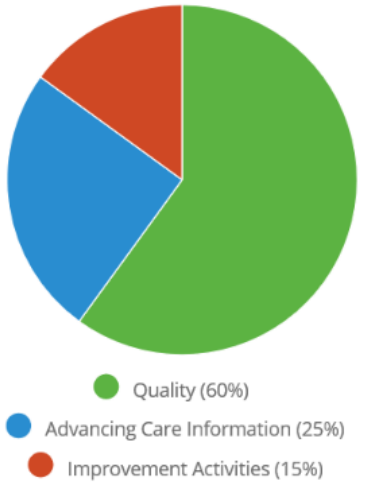
Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, chose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

2017 MIPS Performance



Select Measures

Search All by keyword

All | Search for... | SEARCH

Filter by:

High Priority Measure | Data Submission Method | Specialty Measure Set

Select Measures

Search All by keyword

Filtered | Search for... | SEARCH

Filter by:

High Priority Measure | Data Submission Method | Specialty Measure Set

- [ ] Allergy/Immunology
- [ ] Anesthesiology
- [ ] Cardiology
- [ ] Dermatology
- [ ] Diagnostic Radiology
- [ ] Electrophysiology Cardiac Specialist
- [ ] Emergency Medicine
- [ ] Gastroenterology
- [ ] General Oncology
- [ ] General Practice/Family Medicine
- [ ] General Surgery
- [x] Hospitalists
- [ ] Internal Medicine
- [ ] Interventional Radiology
- [ ] Mental/Behavioral Health
- [ ] Neurology
- [ ] Obstetrics/Gynecology
- [ ] Ophthalmology
- [ ] Orthopedic Surgery
- [ ] Otolaryngology
- [ ] Pathology
- [ ] Pediatrics
- [ ] Physical Medicine
- [ ] Plastic Surgery
- [ ] Preventive Medicine
- [ ] Radiation Oncology
- [ ] Rheumatology
- [ ] Thoracic Surgery
- [ ] Urology
- [ ] Vascular Surgery

Showing

> Documentation of Current Medications in the Medical Record — ADD

Disclaimer

*MIPS eligible clinicians or groups are expected to report on applicable measures. "Applicable" is defined as measures relevant to a particular MIPS eligible

Table 1: Using Data in Benchmark to Estimate Points (For Non-Inverse Measures)*

Decile	Number of Points Assigned for the 2017 MIPS Performance Period
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

**For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and decile 10 has the lowest value.*

Learn More About Improvement Activities and APMs (379KB)	PDF	December 29th, 2016
APMs: Medicaid Models and All-Payer Models (388KB)	PDF	December 29th, 2016
FOR REGISTRIES, QUALIFIED CLINICAL DATA REGISTRIES (QCDRS) & EHR VENDORS		
Quality Measure Specifications (249.3MB)	ZIP	December 29th, 2016
Quality Measure Specifications Supporting Documents (8.3MB)	ZIP	February 13th, 2017
2017 Quality Benchmarks (193KB)	ZIP	December 29th, 2016
Quality Measure Encounter Codes (131KB)	ZIP	December 29th, 2016
Advancing Care Information Measure Specifications (3.9MB)	ZIP	December 29th, 2016
Advancing Care Information Measure Specifications Fact Sheet (148KB)	PDF	December 29th, 2016
Advancing Care Information for Vendors (82KB)	PDF	December 29th, 2016

https://qpp.cms.gov/resources/education

Measure_Name	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Diabetes: Hemoglobin A1c Poor Control	35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 - 10.01	10.00 - 7.42	7.41 - 4.01	<= 4.00	No
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	42.12 - 54.99	55.00 - 71.72	71.73 - 82.13	82.14 - 99.46	99.47 - 99.99	--	--	100	No
Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	77.31 - 80.64	80.65 - 91.19	91.20 - 96.66	96.67 - 98.82	98.83 - 99.99	--	--	100	Yes
Pneumonia Vaccination Status for Older Adults	39.78 - 51.32	51.33 - 61.67	61.68 - 70.47	70.48 - 77.77	77.78 - 84.49	84.50 - 91.99	92.00 - 99.06	>= 99.07	No
Pneumonia Vaccination Status for Older Adults	14.13 - 23.25	23.26 - 33.02	33.03 - 43.58	43.59 - 53.96	53.97 - 63.60	63.61 - 74.54	74.55 - 85.52	>= 85.53	No
Pneumonia Vaccination Status for Older Adults	12.24 - 24.02	24.03 - 36.34	36.35 - 48.51	48.52 - 58.95	58.96 - 68.05	68.06 - 77.77	77.78 - 90.19	>= 90.20	No
Breast Cancer Screening	38.46 - 48.01	48.02 - 55.67	55.68 - 62.78	62.79 - 69.41	69.42 - 77.18	77.19 - 87.87	87.88 - 98.52	>= 98.53	No
Colorectal Cancer Screening	29.50 - 42.36	42.37 - 53.84	53.85 - 64.40	64.41 - 75.40	75.41 - 84.67	84.68 - 93.13	93.14 - 99.99	100	No
Diabetes: Eye Exam	50.57 - 80.68	80.69 - 90.05	90.06 - 94.11	94.12 - 96.66	96.67 - 98.57	98.58 - 99.99	--	100	No
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	71.03 - 74.18	74.19 - 76.51	76.52 - 78.94	78.95 - 81.10	81.11 - 83.99	84.00 - 87.79	87.80 - 95.99	>= 96.00	No
Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	45.69 - 77.37	77.38 - 97.77	97.78 - 99.99	--	--	--	--	100	Yes

Resource Use – 0% of Score for 2017*

- CMS will calculate from claims over 40 episode-specific measures to account for differences among specialties.
  - For cost measures, clinicians that deliver more efficient care achieve better performance and score the highest points (the most efficient resource use).

"Episodes of care" roll up all costs of inpatient and outpatient care (including imaging, laboratory, drugs, rehabilitation, etc).

*By statute must make up 30% of the MIPS score for payment year 2021.

Initial Episode-based Cost Measures

- Aortic/mitral value surgery
- CABG
- Hip/Femur Fracture or Dislocation Treatment
- Cholecystectomy and common duct exploration
- Colonoscopy and biopsy
- TURP for BPH
- Lens and cataract procedures
- Hip replacement or repair
- Knee arthroplasty
- Mastectomy

Will affect payment in 2018.

MIPS Performance Category:

Improvement Activities – 15% of Score

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- ***Clinicians choose*** from 90+ activities under 9 subcategories:

1. Expanded Practice Access	2. Population Management	3. Care Coordination
4. Beneficiary Engagement	5. Patient Safety and Practice Assessment	6. Participation in an APM
7. Achieving Health Equity	8. Integrating Behavioral and Mental Health	9. Emergency Preparedness and Response

Select Improvement Activities

Search All by keyword

All | Search for... | SEARCH

Filter by:

Subcategory Name | Activity Weighting

Showing **92** Activities

Add All Activities

- Additional improvements in access as a result of QIN/QIO TA — ADD
- Administration of the AHRQ Survey of Patient Safety Culture — ADD
- Annual registration in the Prescription Drug Monitoring Program — ADD
- Anticoagulant management improvements — ADD
- Care coordination agreements that promote improvements in patient tracking across settings — ADD

Selected Activites

0 Activities Added

Once you select measures they will appear here

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https://qpp.cms.gov/measures/ia

MIPS Scoring for Improvement Activities

(15% of Final Score in Transition Year)

Total points = 40

Activity Weights

- Medium = 10 points
- High = 20 points

Alternate Activity Weights*

- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

MIPS Performance Category:

Advancing Care Information

- Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

Option 1	*Option 2*
Advancing Care Information Objectives and Measures	Combination of the two measure sets

For those using 2014 Certified EHR Technology:

Option 1	*Option 2*
2017 Advancing Care Information Transition Objectives and Measures	Combination of the two measure sets

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MIPS Scoring - Advancing Care Information
(25% of Final Score): Base Score

50% Base score (worth 50%)

Clinicians must submit a numerator/denominator or
Yes/No response for each of the following required measures:

Advancing Care Information Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send a Summary of Care
- Request/Accept a Summary of Care

2017 Advancing Care Information Transition Measures

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Health Information Exchange

0% Failure to meet reporting requirements will result in base score of zero, and an advancing care information performance score of zero.

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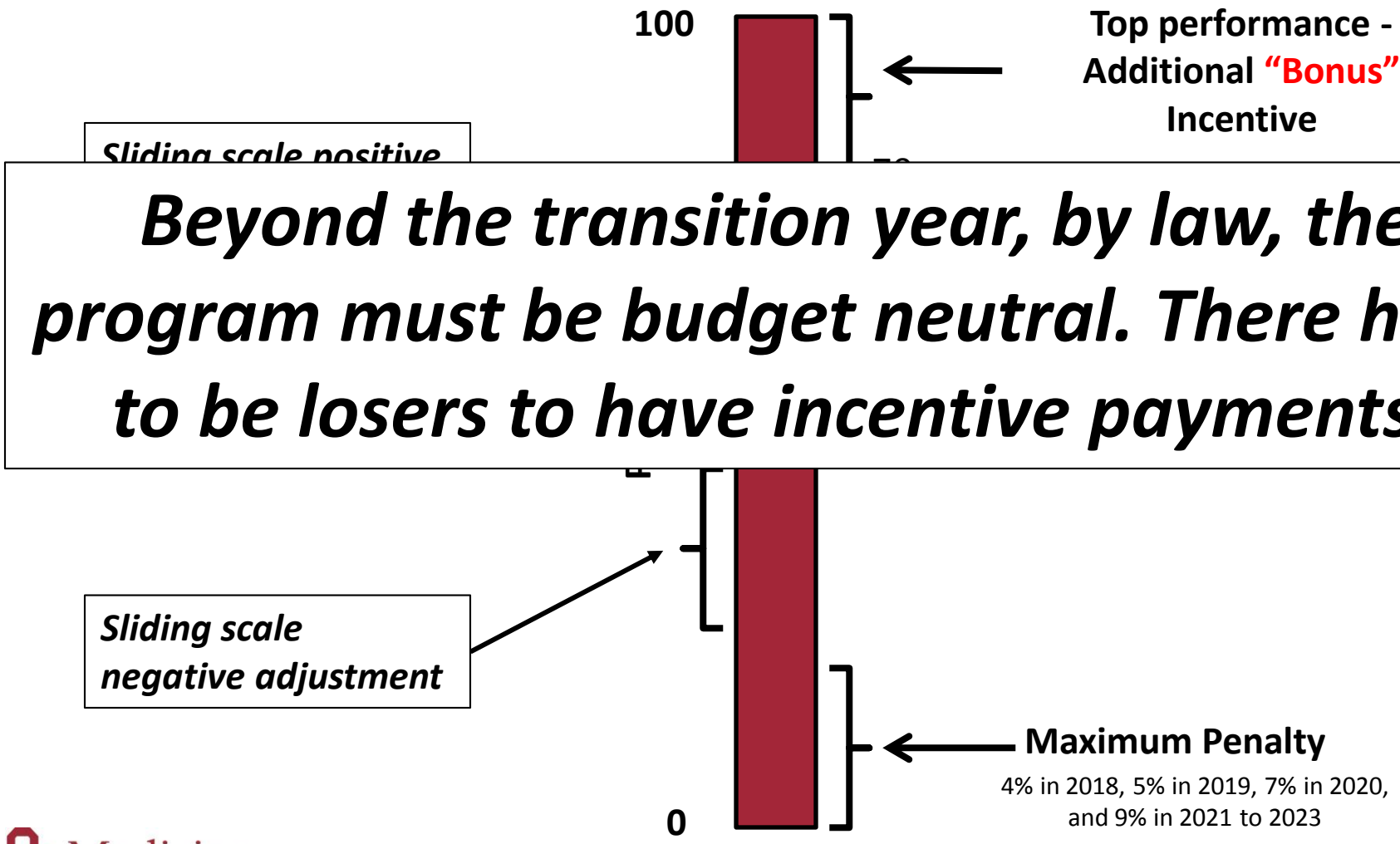
MIPS Scoring - Advancing Care Information

(25% of Final Score): Performance Score

Advancing Care Information Measures	
Measure	Performance Score
Provide Patient Access	Up to 10%
Patient-Specific Education	Up to 10%
View, Download and Transmit (VDT)	Up to 10%
Secure Messaging	Up to 10%
Patient-Generated Health Data	Up to 10%
Send a Summary of Care	Up to 10%
Request/Accept a Summary of Care	Up to 10%
Clinical Information Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Advancing Care Information Transitional Measures	
Measure	Performance Score
Provide Patient Access	Up to 20%
Health Information Exchange	Up to 20%
View, Download, or Transmit	Up to 10%
Patient-Specific Education	Up to 10%
Secure Messaging	Up to 10%
Medication Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Scoring under MIPS



Beyond the transition year, by law, the program must be budget neutral. There have to be losers to have incentive payments!

Transition Year 2017

Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Alternate Payment Models (APMs)

- "Substantial portion" of revenues* from "approved" alternate payment models
  - For now, very few "approved" APMs
  - Not subject to MIPS
- Receive 5% lump sum bonus payments for years 2019-2024
- Receive a higher fee schedule update from 2026 onward

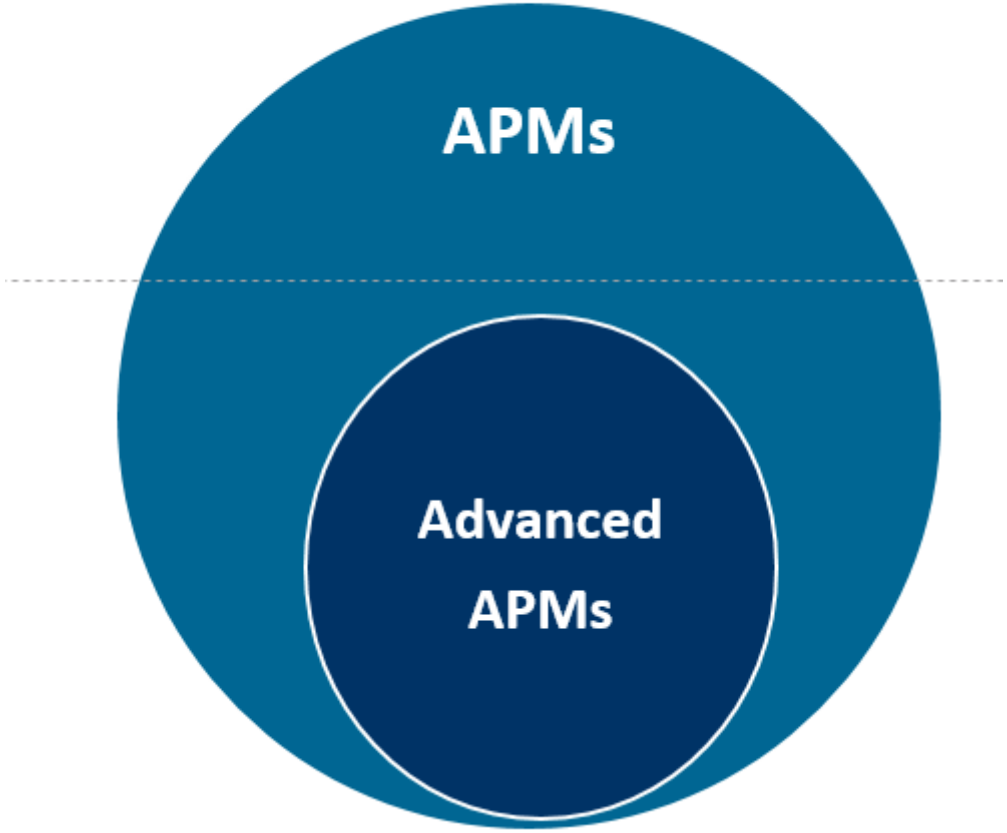
What is an eligible APM?

Eligible APMs are the **most**

The practice must bear more than nominal financial risk!

- ✓ **Base payment on quality** measures comparable to those in MIPS
- ✓ Require use of certified **EHR** technology
- ✓ Either (1) bear more than nominal **financial risk** for monetary losses **OR** (2) be a **medical home model expanded** under CMMI authority

Advanced APMs are a Subset of APMs



Qualifying Advanced APMs

What models are Advanced APMs?

In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Advanced APM – to avoid MIPS

Table 1: Requirements for APM Incentive Payments for Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

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Docs face stark choices under new Medicare pay proposal

By Beth Kutscher | April 30, 2016

The new draft regulations designed to ch
represent the most sweeping overhaul th
business of running a physician practice

The goal is to have the vast majority of
models that reward doctors for the qualit
patients they see.

"You can no longer afford to ignore quality reporting"

The Advisory Board Company

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Practice Notes

With MACRA, 2017 will be 'year of reckoning' for physician payment

2:56 PM on May 2, 2016 by Rivka Friedman

Last Wednesday, CMS released its proposed rule for MACRA, the Medicare Access and CHIP Reauthorization Act, which replaced SGR and redefined parameters for Medicare physician reimbursement.

http://www.modernhealthcare.com/article/20160430/MAGAZINE/304309988

https://www.advisory.com/research/medical-group-strategy-council/practice-notes/2016/05/macra-proposed-rule

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- **558,885 EPs are currently subject to the 2016 PQRS negative payment adjustment.***
- **Of those professionals subject to the adjustment**
  - 466,351 were non-participants (those EPs who did not attempt to participate)
  - 92,534 were participants who were unsuccessful in meeting the reporting requirements

*Based on 2014 PQRS reporting.

What do you need to do now?

- Determine if you are MIPS eligible (CMS will notify you)
- Assuming you are MIPS eligible, determine your pace of participation for 2017
  - If you don't participate, you will see a 4% reduction in your Medicare Part B payment in 2019
- Visit www.qpp.cms.gov to learn more about the program and use the tools to pick measures
- Start thinking about 2018
  - Many experts expect the cost episode measures to differentiate practices on MIPS performance

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