Making Sense of MACRA

May 12, 2016

Agenda

- **Welcome**
- **Mark Segal, PhD**
  - Representative of eHI's Policy Steering Committee; Vice President of Government and Industry Affairs, GE Healthcare IT
- **Robert Anthony**
  - Deputy Director of the Quality Measurement & Value-Based Group (QMVIG) in the Center for Clinic Standards and Quality (CCSQ) at the Centers for Medicare & Medicaid Services (CMS)
- **Samuel W. Ho, MD**
  - Executive Vice President and Chief Medical Officer, United Healthcare
- **Lewis G. Sandy, M.D., F.A.C.P.**
  - Senior Vice President, Clinical Advancement, UnitedHealth Group

eHEALTH INITIATIVE

Reminder

Please mute your line when not speaking

(* 6 to mute, *7 to unmute)

This call is being recorded

Overview of eHealth Initiative

- Since 2001, eHealth Initiative (c6) and the Foundation for eHealth Initiative (c3) have conducted research, education and advocacy to demonstrate the value of technology and innovation in health.

- The missions of the two organizations are the same: to drive improvement in the quality, safety, and efficiency of healthcare through information and technology.

- Our work is centered around the *2020 Roadmap*. The primary objective of the *2020 Roadmap* is to craft a multi-stakeholder solution to enable coordinated efforts by public and private sector organizations to transform care delivery through data exchange and health IT.

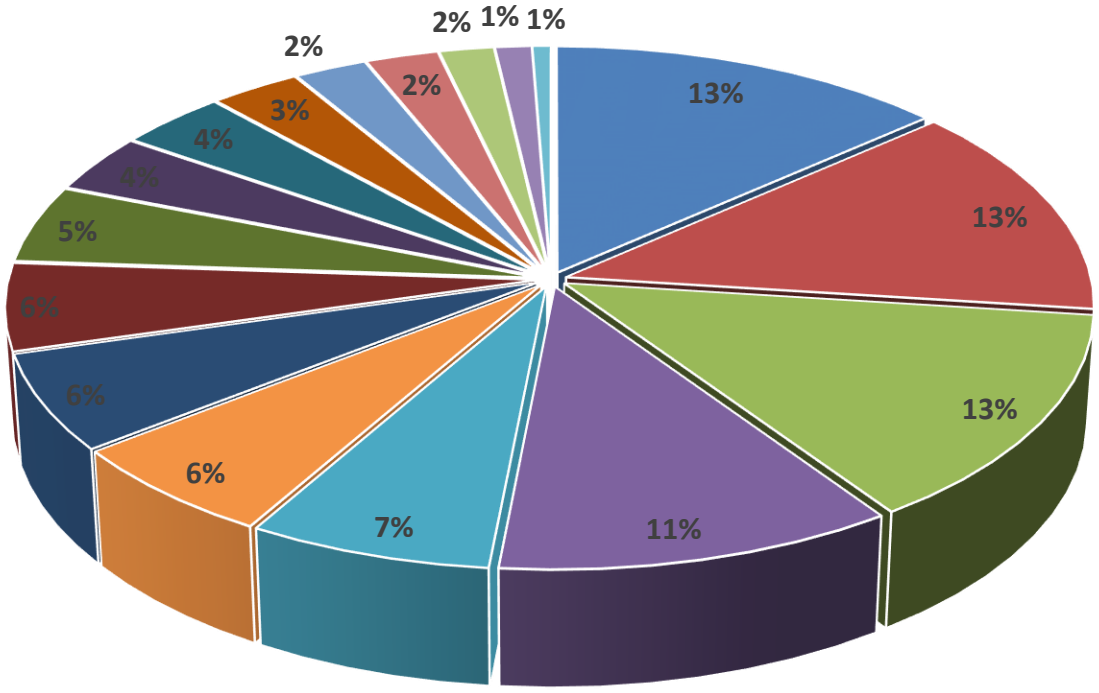
Multi-Stakeholder Leaders in Every Sector of Healthcare

2016 Board of Directors

- **Christopher Ross, Chief Information Officer, Mayo Clinic, Chair, eHI Board of Directors**
- **Sam Ho, MD, Executive Vice President and Chief Medical Officer, UnitedHealthcare, Chair Foundation**
- Paul Eddy, Chief Information Office, **Wellmark BCBS**
- Daniel T. Garrett, Principal and Health Information Technology Practice Leader**,** **PwC**
- John Glaser, PhD, Senior Vice President**,** **Cerner**
- Dan Haley, Senior VP and General Counsel, **AthenaHealth**
- Brian Kelly, MD President, Payer & Provider Solutions, **Quintiles**
- Kristine Martin Anderson, Partner, **Booz Allen Hamilton**
- James Murray, Vice President, Information Systems, **CVS Caremark**
- Shawn Ramer, PhD, Senior Vice President, **Bristol-Myers Squibb**
- Richard Ratliff, Global Managing Director, Connected Health IT Solutions, **Accenture**
- Michael Simpson, CEO and President, **Caradigm**
- Steven Stack, MD, President Board of Trustees, **American Medical Association**
- Russ Thomas, Chief Executive Officer, **Availity**
- Susan Turney, MD, Chief Executive Officer, **Marshfield Clinic Health System**

eHEALTH INITIATIVE

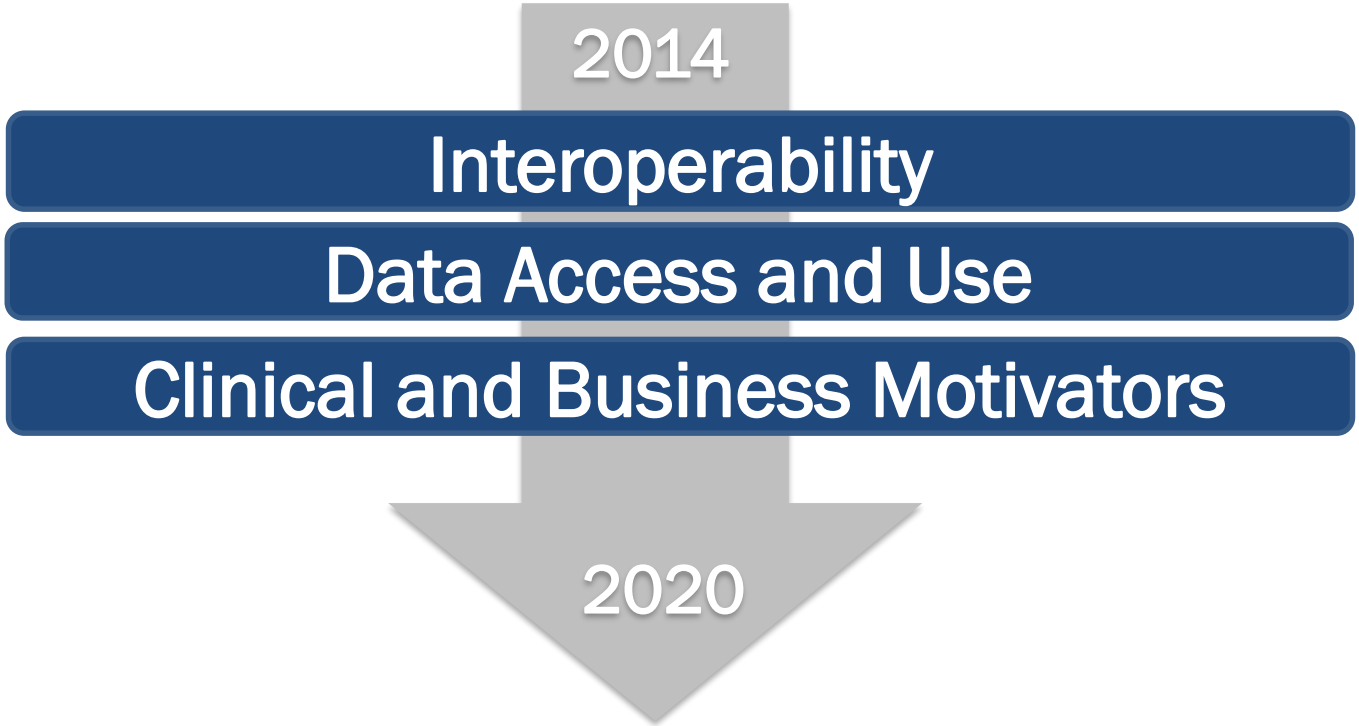
eHI Members: A Diverse Constituency



- Provider or ACO
- Healthcare Consulting & IT Integration
- Information Exchange, HIE or Network
- Clinical Prof. Assoc. or Medical Societies
- Vendor
- Health IT Applications or Hardware
- Research, Analytics or Educational
- Non-Profit Assoc. or Professional Society
- Pharmaceutical Manufacturer
- Public Health or State
- Standards, Quality or Accrediting Group
- Health Plan or Insurance Organization
- Employers, Consumers, or Patients
- Legal Practice
- Pharmacy-related Organization
- Lab
- Medical Device Manufacturer

eHEALTH INITIATIVE

A Framework to Transform Patient Care



eHEALTH INITIATIVE

2016 Member Activities

Workgroups

- **Policy Steering Committee**: board appointment group that responds on behalf of organizations, provides input from stakeholder entities, detailed recommendations on interoperability,
- **Interoperability Workgroup:** developing use cases and online resources that better define the cost/benefits of information sharing and interoperability, identify and prioritize interoperability use cases to determine gaps and inefficiencies in infrastructure.
- **Executive Advisory Board on Privacy and Security (Data Access and Use)** focus on initiating and maintaining culture of security and commitment to data security. Strategy guidance for CIOs, CISOs, CPOs to address data security. Focused on cybersecurity and third party sharing.
- **Data Analytics Workgroup:** Focusing on challenges related to population health and analytics. Currently looking at challenges identified through eHI's Survey of Accountable Care Organizations.
- **Business and Clinical Motivators Best Practices –** identify best practices in the private sector in payer, provider and patient-consumer organizations. Identify existing resources and opportunities for tools to ease HIT integration in daily lives of consumers and providers.

- **Surveys**
  - Population health
  - Accountable Care
  - Data Exchange
  - Interoperability Challenges

eHEALTH INITIATIVE

Making Sense of MACRA

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

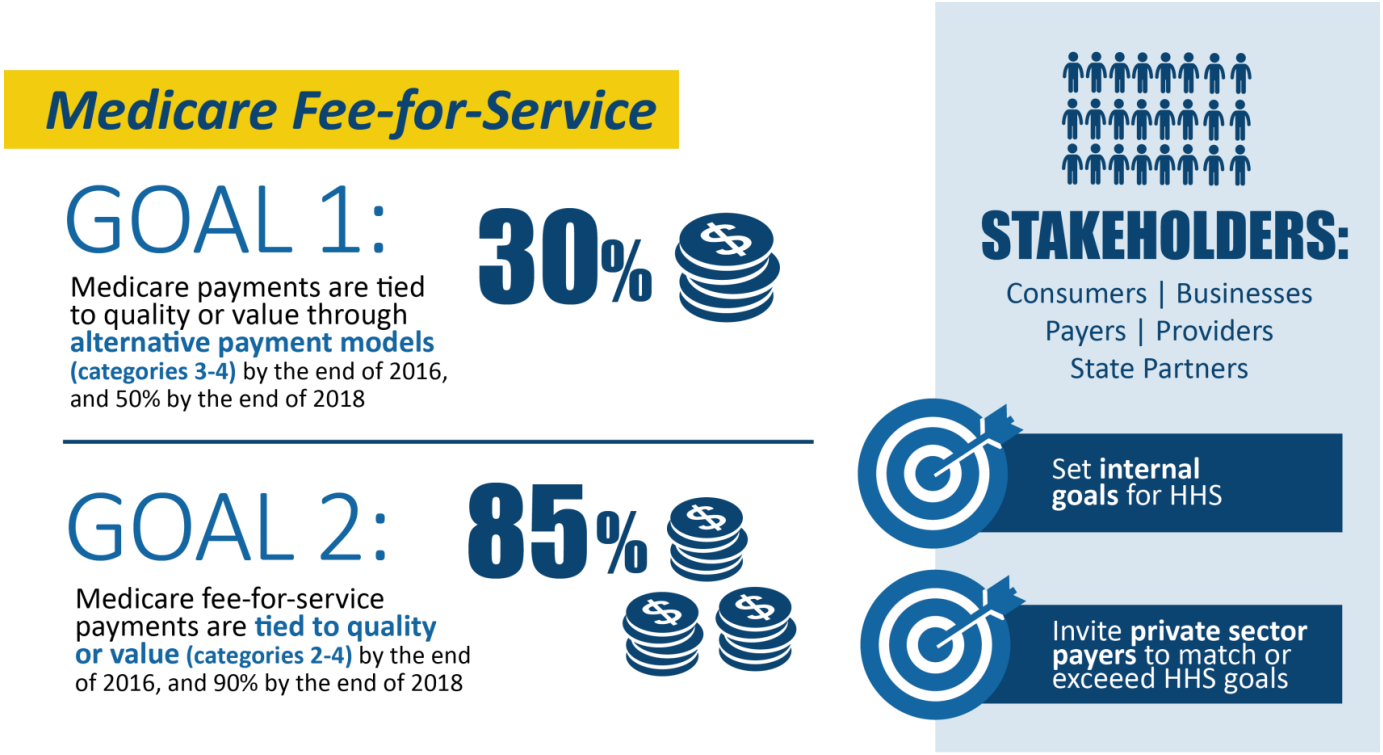
This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

KEY TOPICS:

1) The Quality Payment Program and HHS Secretary's Goals
2) What is the Quality Payment Program?
3) How do I submit comments on the proposed rule?
4) The Merit-based Incentive Payment System (MIPS)
5) What are the next steps?

The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

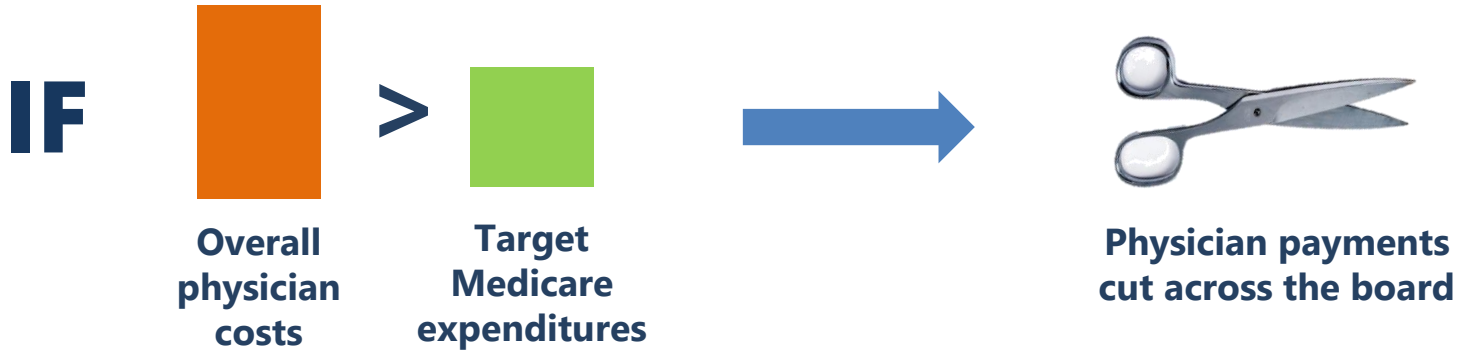


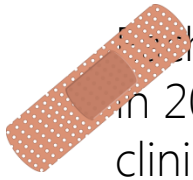
Medicare Payment Prior to MACRA

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





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 Payment Prior to MACRA

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

The Sustainable Growth Rate (SGR)

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)

MACRA **replaces the SGR** with a **more predictable** payment method that **incentivizes value**.

INTRODUCING THE QUALITY PAYMENT PROGRAM

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

MIPS

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)

Value-Based Payment Modifier (VM)

Medicare Electronic Health Records (EHR) Incentive Program

PROPOSED RULE

MIPS: Major Provisions

- ✓ Eligibility (participants and non-participants)
- ✓ Performance categories & scoring
- ✓ Data submission
- ✓ Performance period & payment adjustments

Who Will Participate in MIPS?

Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

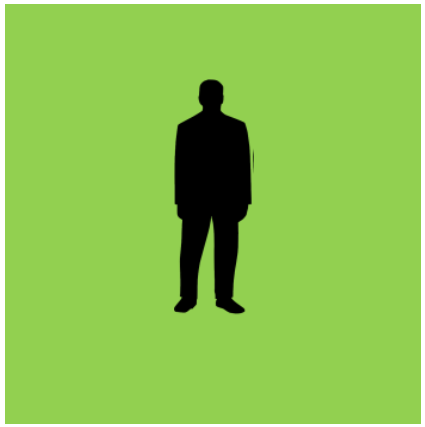
Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation



Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

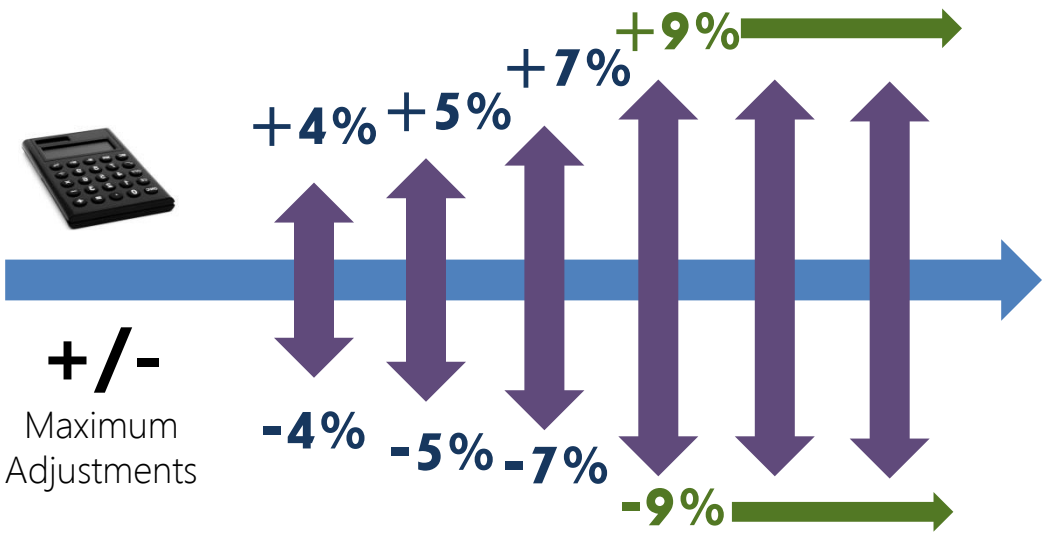
Note: MIPS **does not** apply to hospitals or facilities

PROPOSED RULE
MIPS Timeline

2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	

How much can MIPS adjust payments?

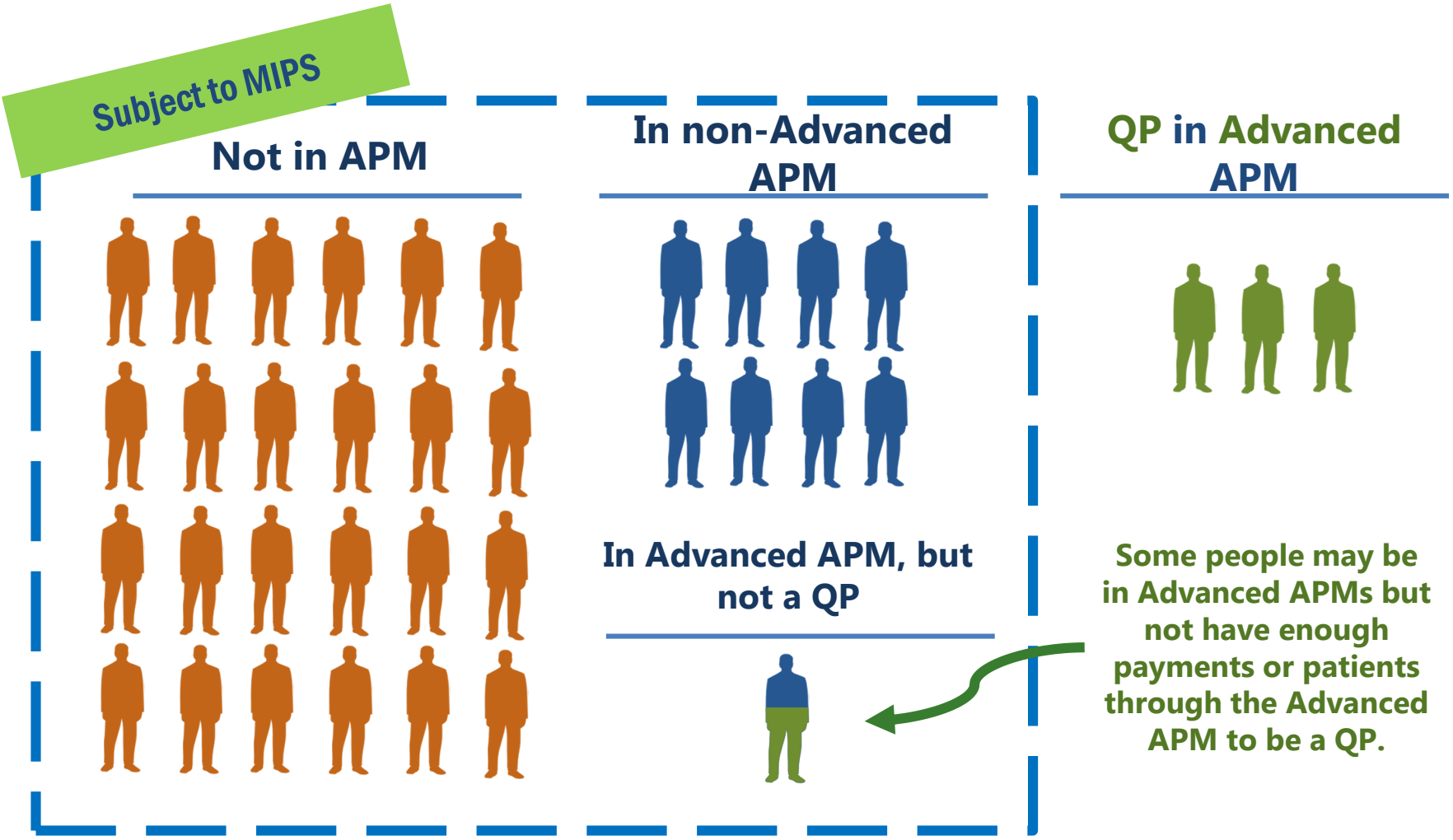
Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

PROPOSED RULE

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Or

Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

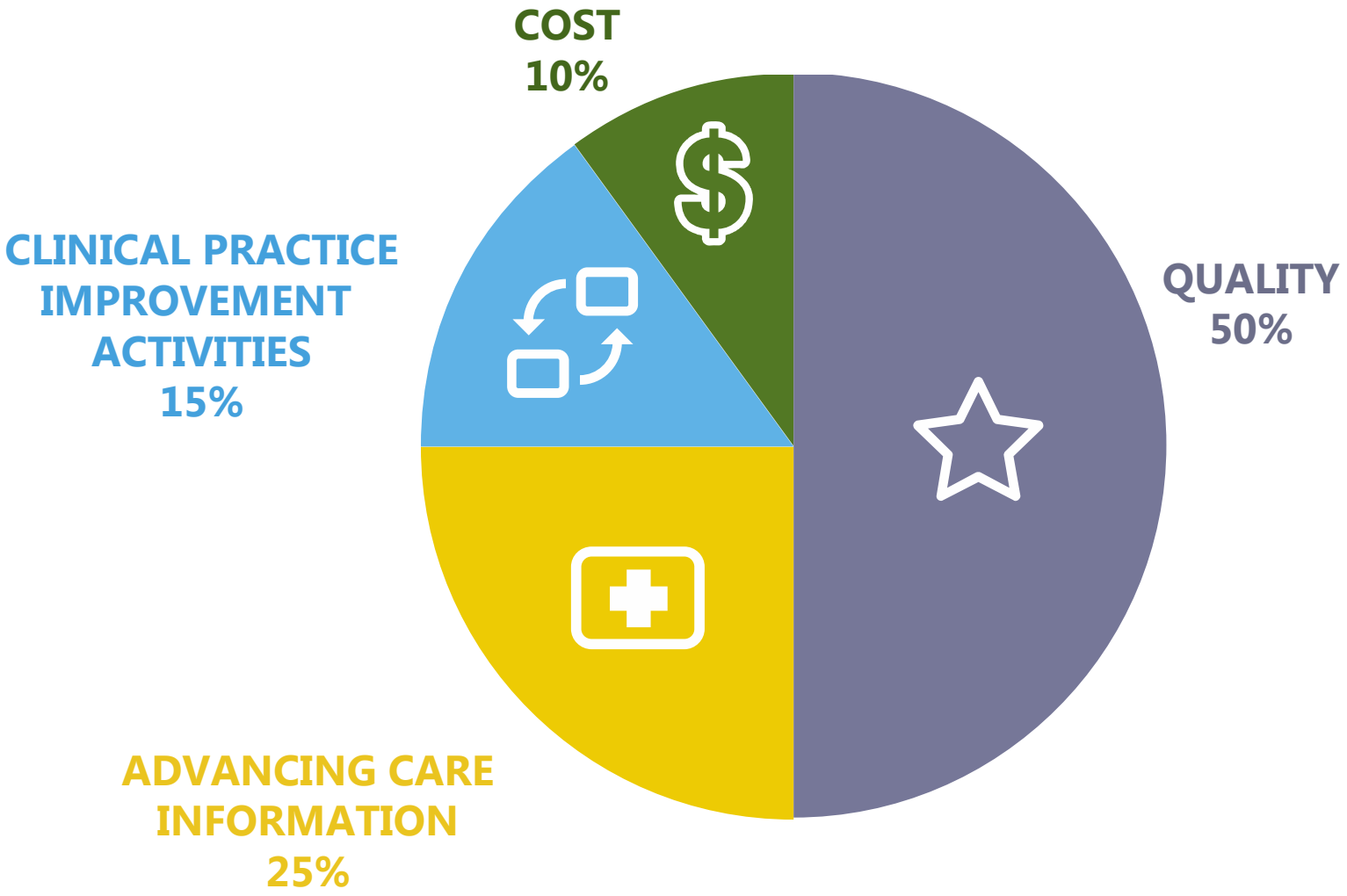
Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

PROPOSED RULE
MIPS: PERFORMANCE CATEGORIES & SCORING

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Year 1 Performance Category Weights for MIPS



What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :

*Proposed quality measures are available in the NPRM

*clinicians will be **able to choose** the measures on which they'll be evaluated

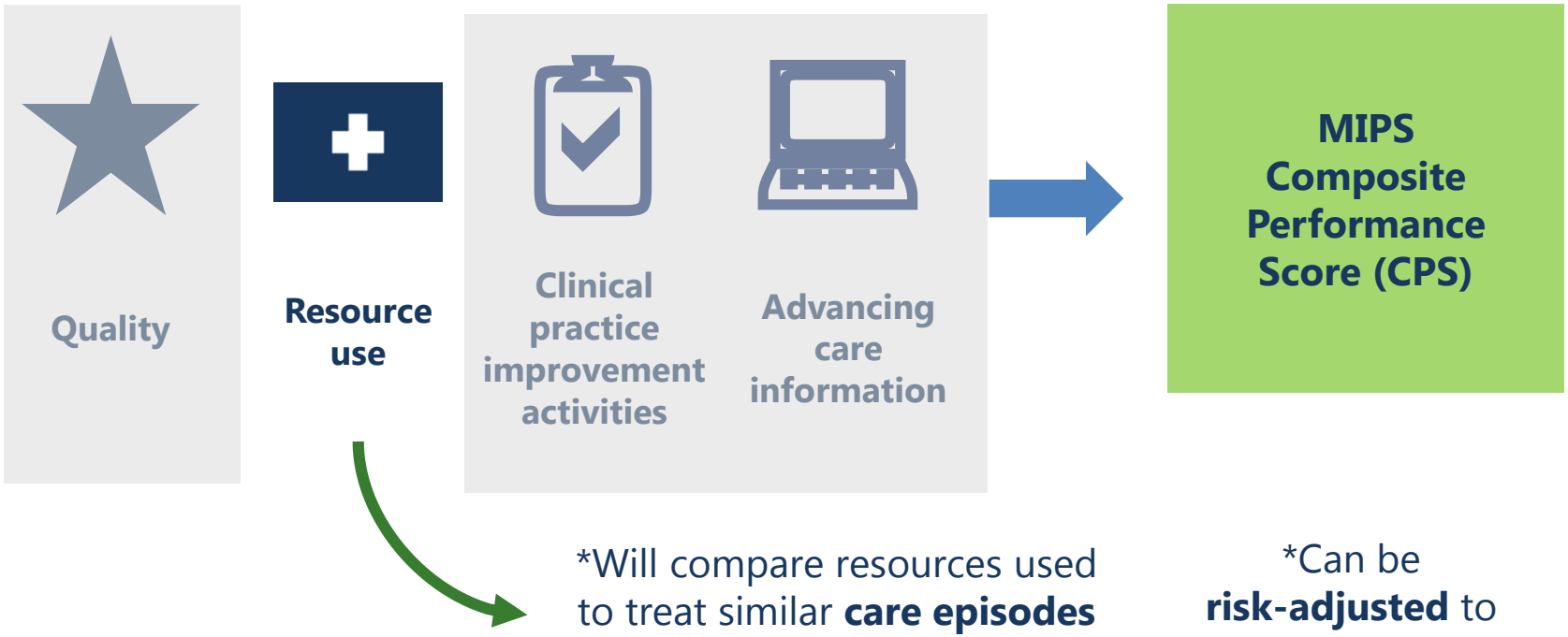
PROPOSED RULE
MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
  - **Reduced from 9 measures to 6 measures with no domain requirement**
  - **Emphasis on outcome measurement**
  - **Year 1 Weight: 50%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
  - **Adding 40+ episode specific measures to address specialty concerns**
  - **Year 1 Weight: 10%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :

PROPOSED RULE

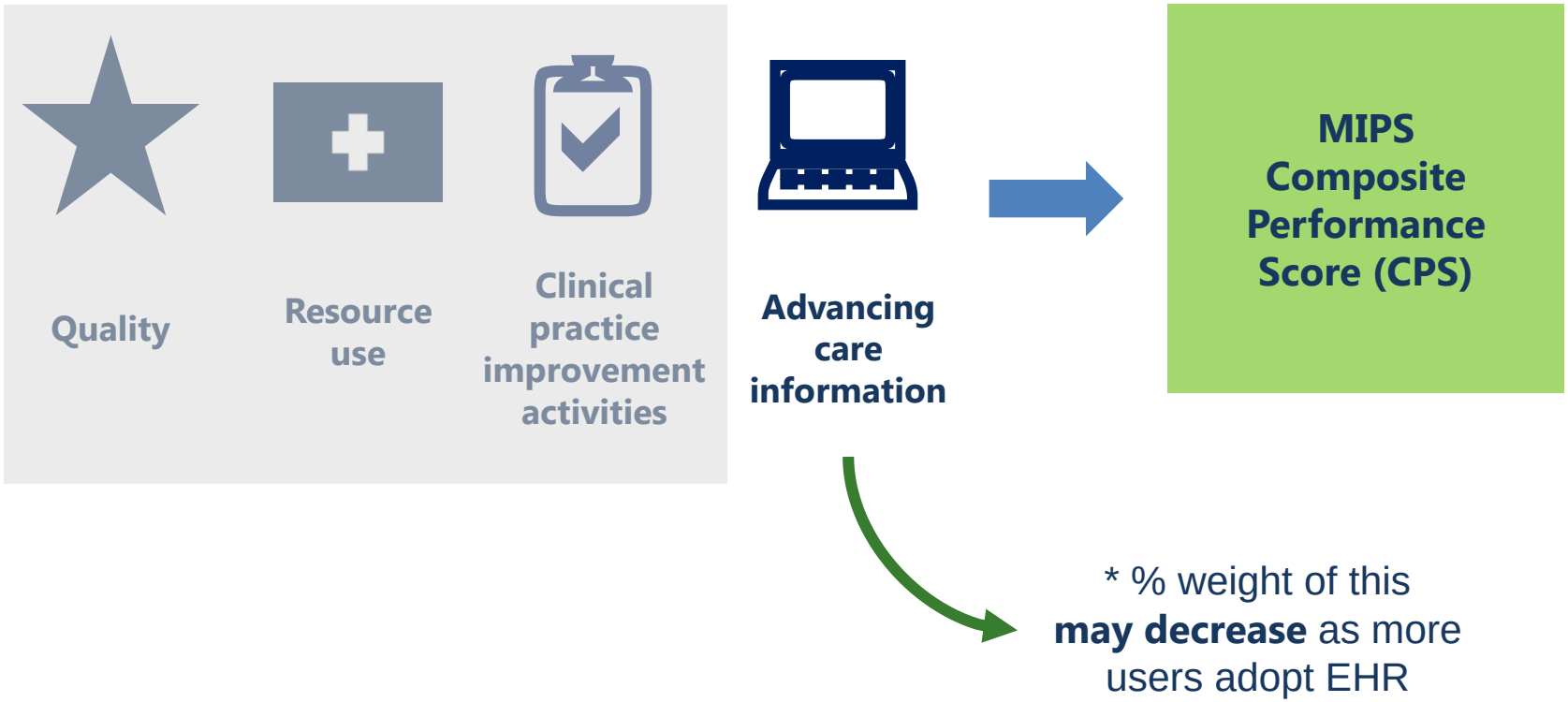
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
  - **Not applicable (new category)**
  - **Year 1 Weight: 15%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Who can participate?

All MIPS Eligible Clinicians

Participating as an..

Individual

or

Group

Optional for 2017

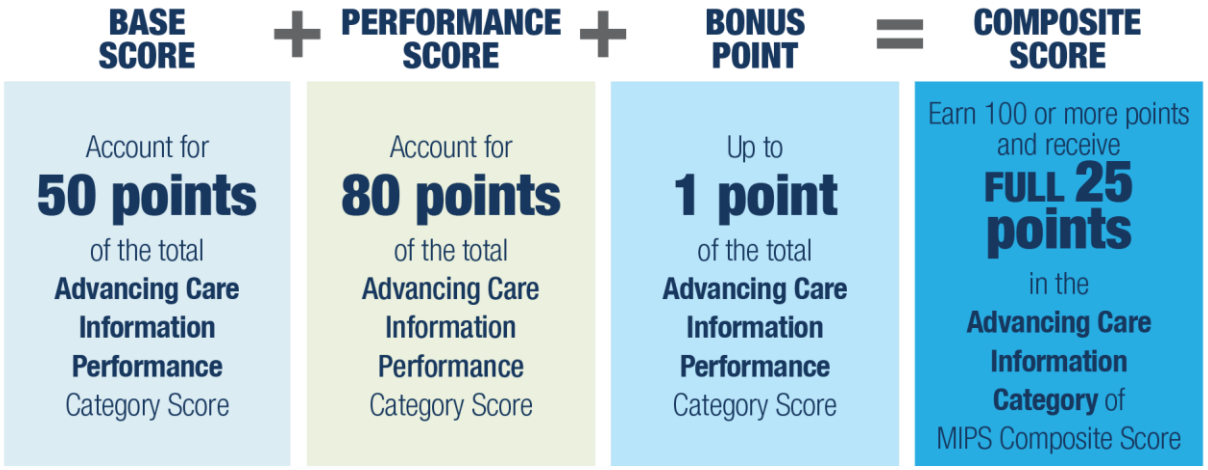
NPs, PAs, Clinical Nurse Specialists, CRNAs

Not Eligible

Facilities (i.e. Skilled Nursing facilities)

PROPOSED RULE

MIPS: Advancing Care Information Performance Category



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

BASE SCORE

Accounts for 50 Percentage Points of the total Advancing Care Information category score.

To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE

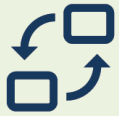
MIPS: Advancing Care Information Performance Category

The Performance Score

The performance score accounts for up to 80 percentage points towards the total Advancing Care Information category score

Patient Electronic Access

Coordination of Care Through Patient Engagement



Health Information Exchange

Physicians and other clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Summary:

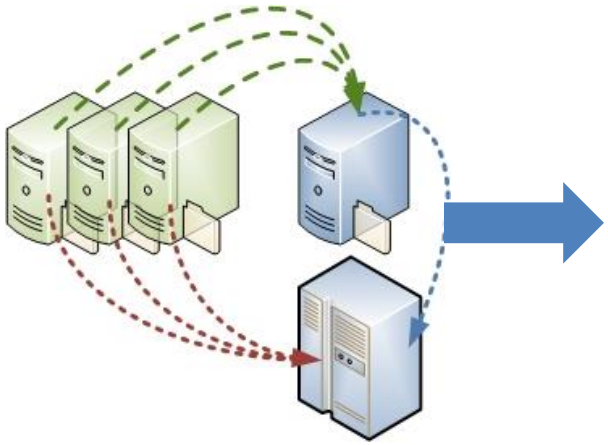
- ✓ **Scoring based on key measures of patient engagement and information exchange.**
- ✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**
- ✓ **Key Changes from Current Program (EHR Incentive):**
  - **Dropped "all or nothing" threshold for measurement**
  - **Removed redundant measures to alleviate reporting burden**
  - **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
  - **Reduced the number of required public health registries to which clinicians must report**
  - **Year 1 Weight: 25%**

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories			
	Performance Category	**Maximum Possible Points per Performance Category**	**Percentage of Overall MIPS Score (Performance Year 1 - 2017)**
	**Quality:** Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
	**Advancing Care Information:** Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
	**Clinical Practice Improvement Activities:** Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
	**Cost:** CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

HOW DO I GET MY DATA TO CMS?
DATA SUBMISSION FOR MIPS



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROPOSED RULE

MIPS Data Submission Options
Quality and Resource Use

	Individual Reporting 	Group Reporting 
Quality	✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Administrative Claims (No submission required) ✓ Claims	✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Administrative Claims (No submission required) ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Resource use	✓ Administrative Claims (No submission required)	✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options
Advancing Care Information and CPIA

	Individual Reporting 	Group Reporting 
Advancing care information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
CPIA	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ Administrative Claims (No submission required)	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR ✓ CMS Web Interface (groups of 25 or more)

PROPOSED RULE
MIPS PERFORMANCE PERIOD & PAYMENT ADJUSTMENT

PROPOSED RULE

MIPS Performance Period

MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Period		Payment Year						

PROPOSED RULE
MIPS: Payment Adjustment

- ✓ **A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.**
- ✓ **A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.**
- ✓ **A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.**

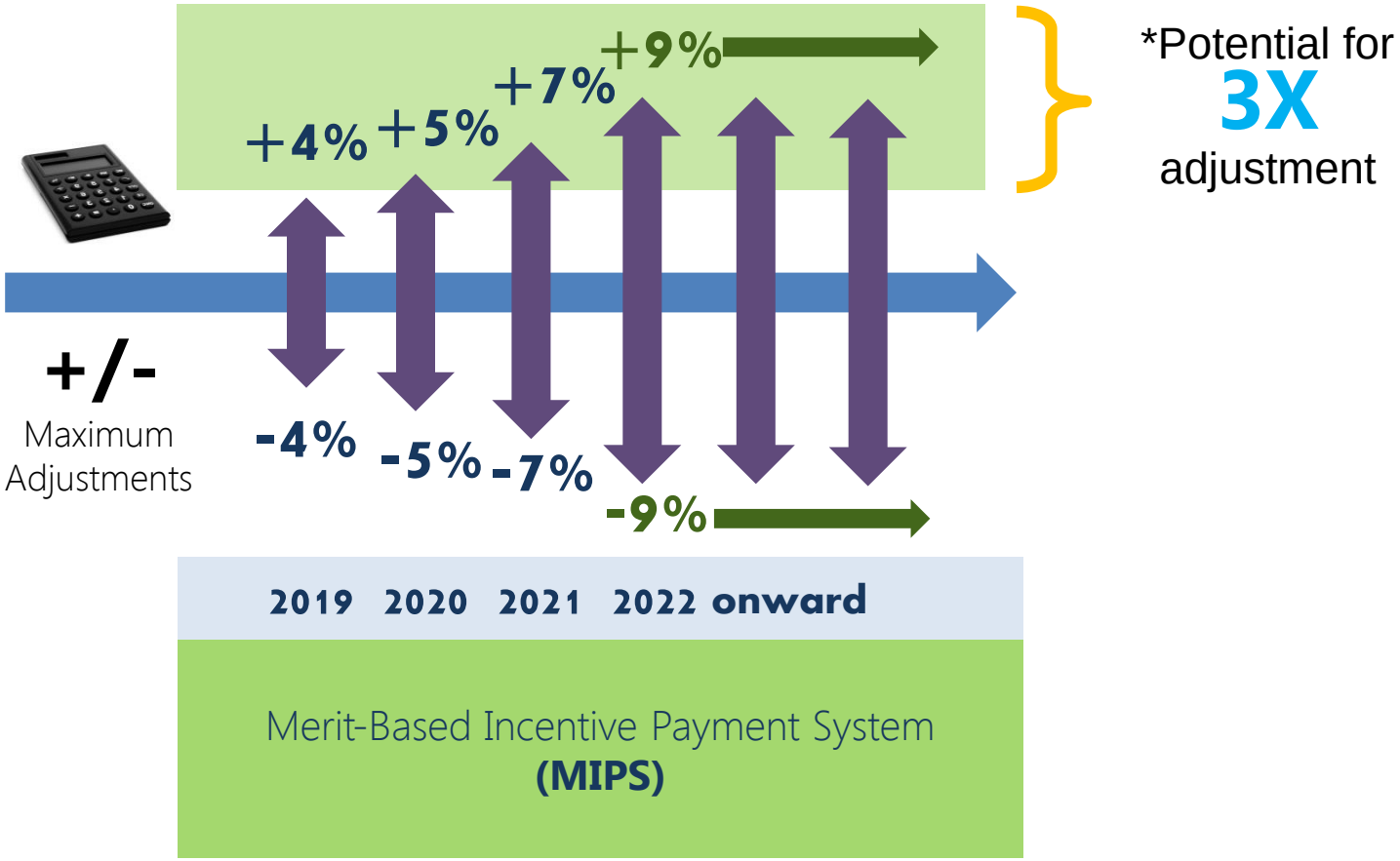
PROPOSED RULE

MIPS: Payment Adjustment

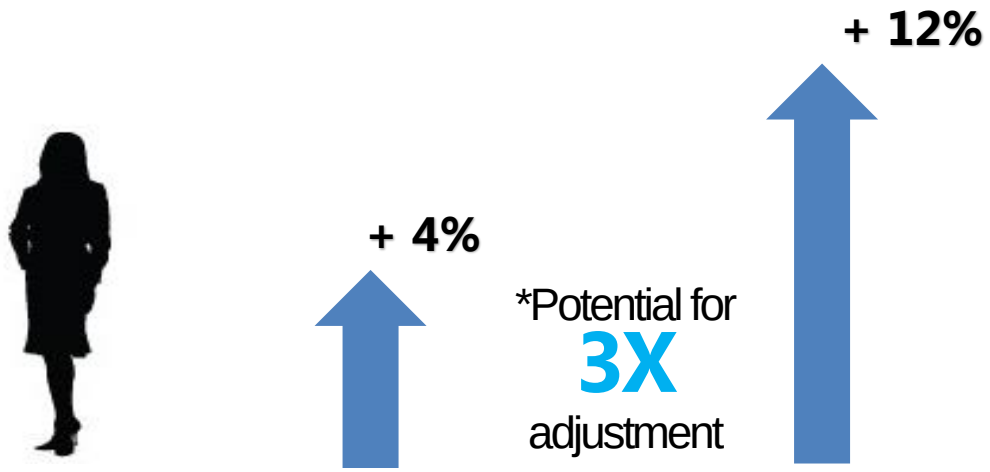
- ✓ A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.
- ✓ An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an "additional performance threshold," defined as the 25th percentile of possible values above the CPS performance threshold.

How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



MIPS: Scaling Factor Example

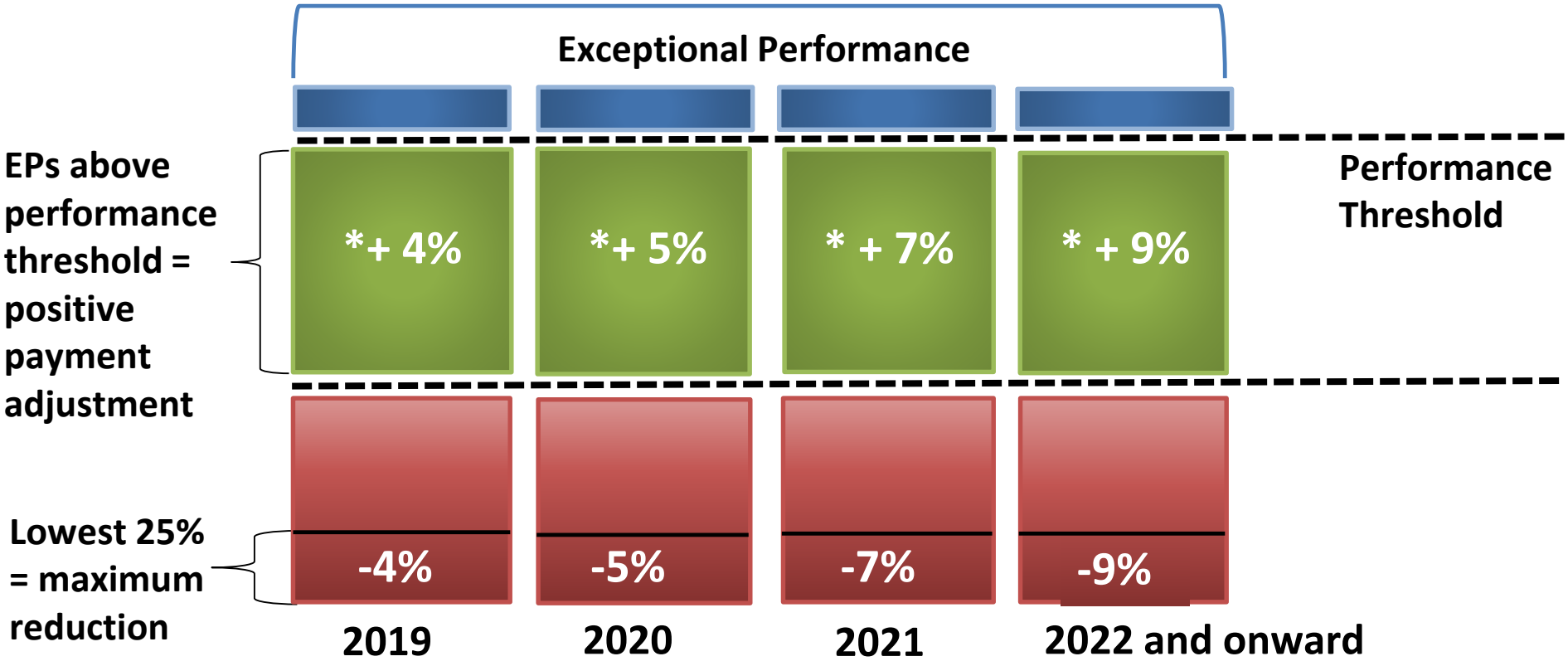


Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024



**MACRA allows potential 3x upward adjustment BUT unlikely*

THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the http://go.cms.gov/QualityPaymentProgram to learn of Open Door Forums, webinars, and more.

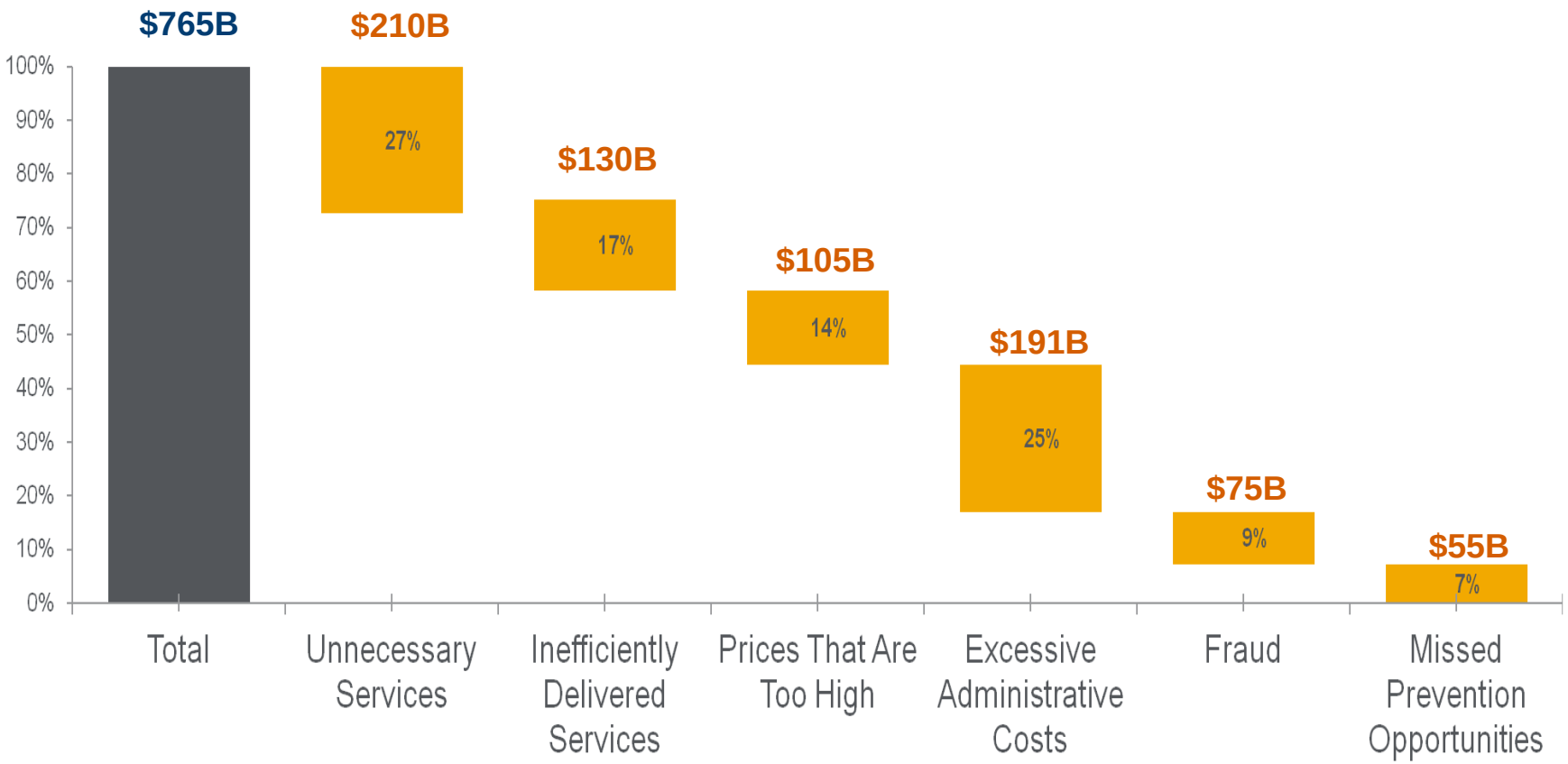
UNITEDHEALTH GROUP

From Volume to Value: Overview of Alternative Payment Models and MACRA

Overview:

- All stakeholders are demanding more value for health spending
  - 30% of all spending is waste
  - Pervasive, persistent, unexplained variation in quality/cost/patient experience
  - FFS rewards volume/intensity, not value
- Significant alternative payment models (APMs) and delivery reforms underway in both private and public sectors, aimed at paying for value
- MACRA-reforming Medicare payment via MIPS and APMs
- Discussion/Q & A

Let's Level Set:
About 30% of All Current Spending is Waste

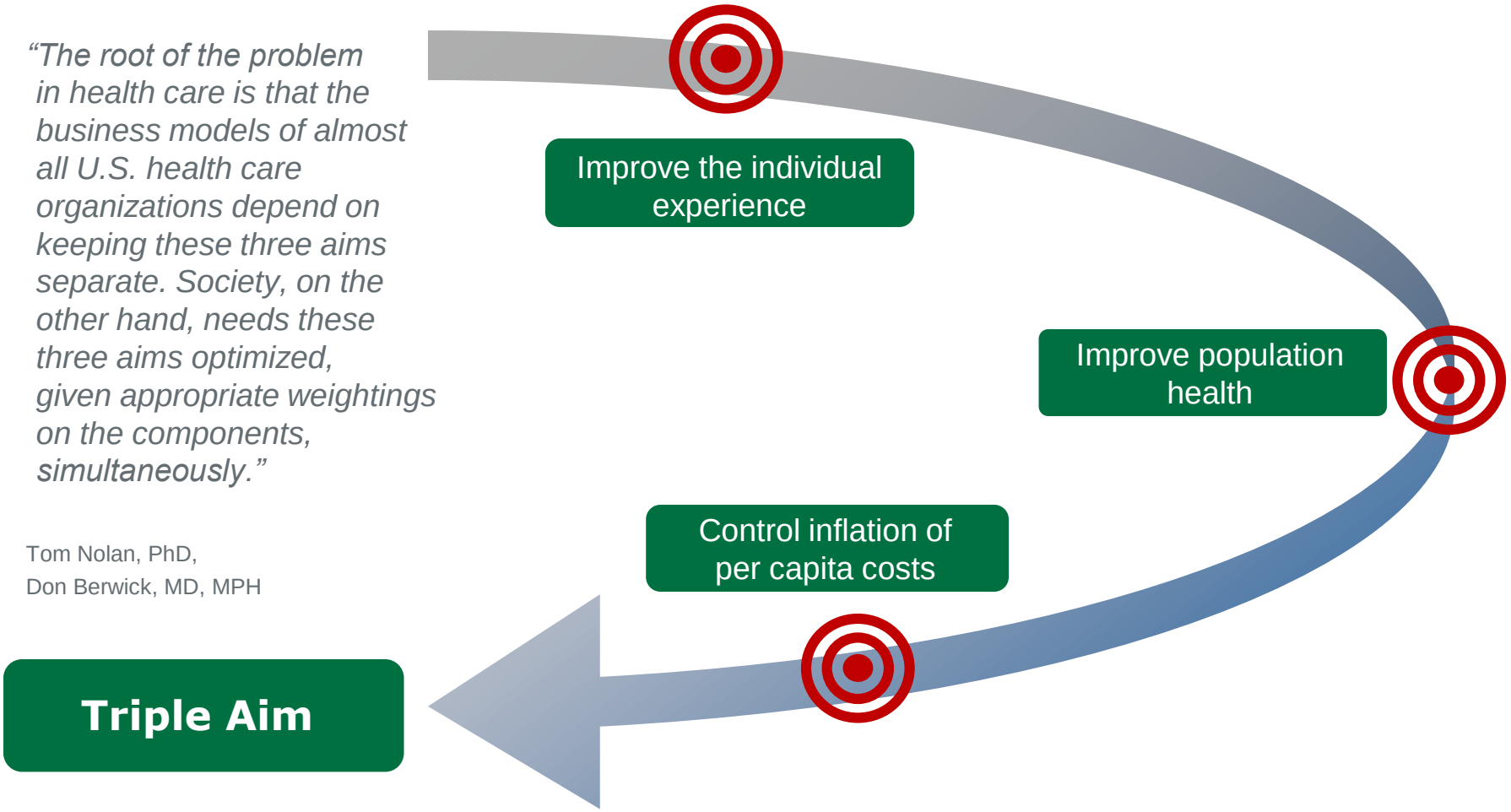


Source: Institute of Medicine: "The health care Imperative: Lowering Costs and Improving Outcomes - Workshop Series Summary"

Focus: Achieving the "Triple Aim"!

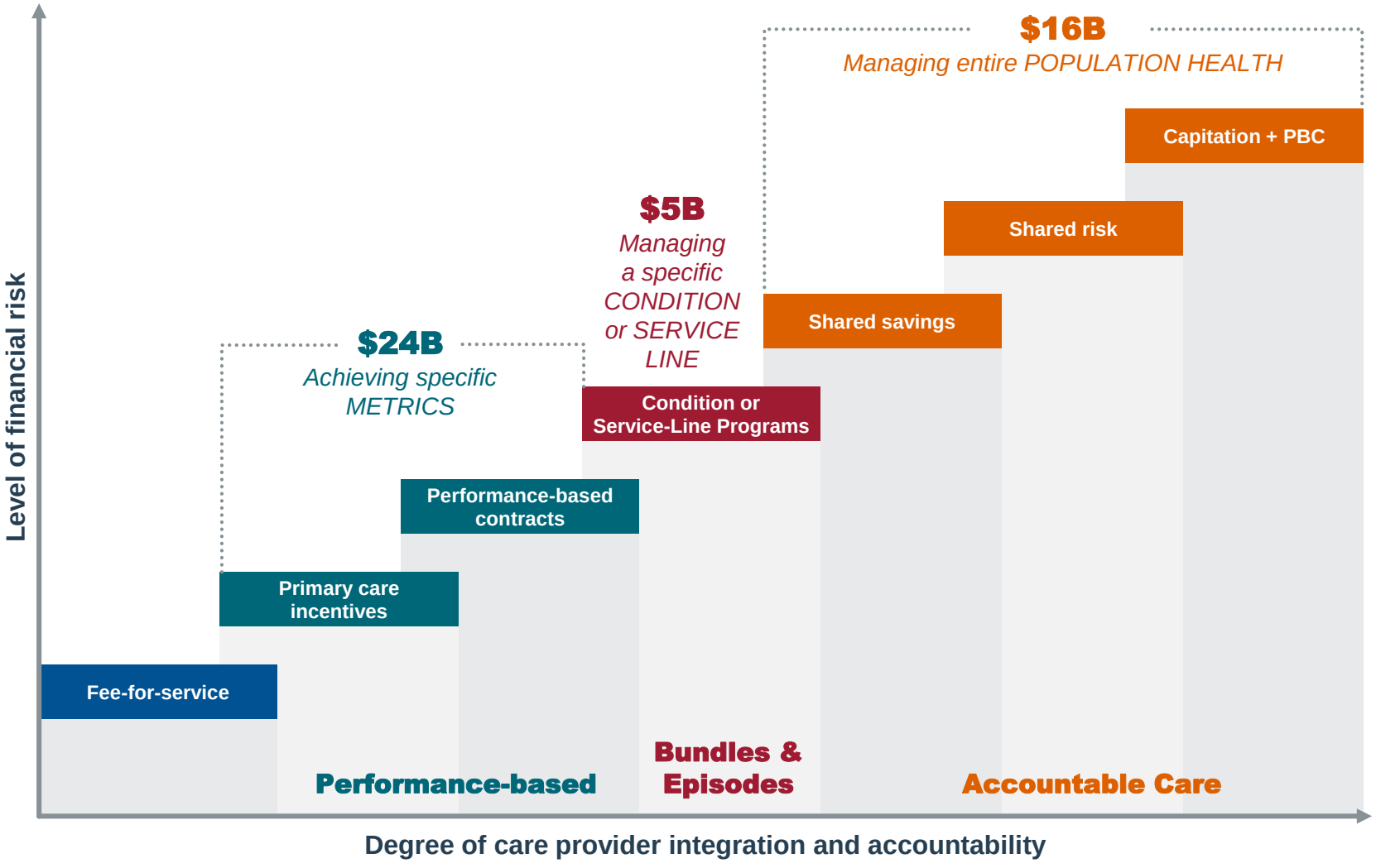
"The root of the problem in health care is that the business models of almost all U.S. health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized, given appropriate weightings on the components, simultaneously."

Tom Nolan, PhD,
Don Berwick, MD, MPH



"The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,

Payment Reform-Wide Range of Models, Rapid Growth



UNITEDHEALTH GROUP

UnitedHealthcare's Payment Reform Experience: National Growth

40%

of spend covered by value-based contracts

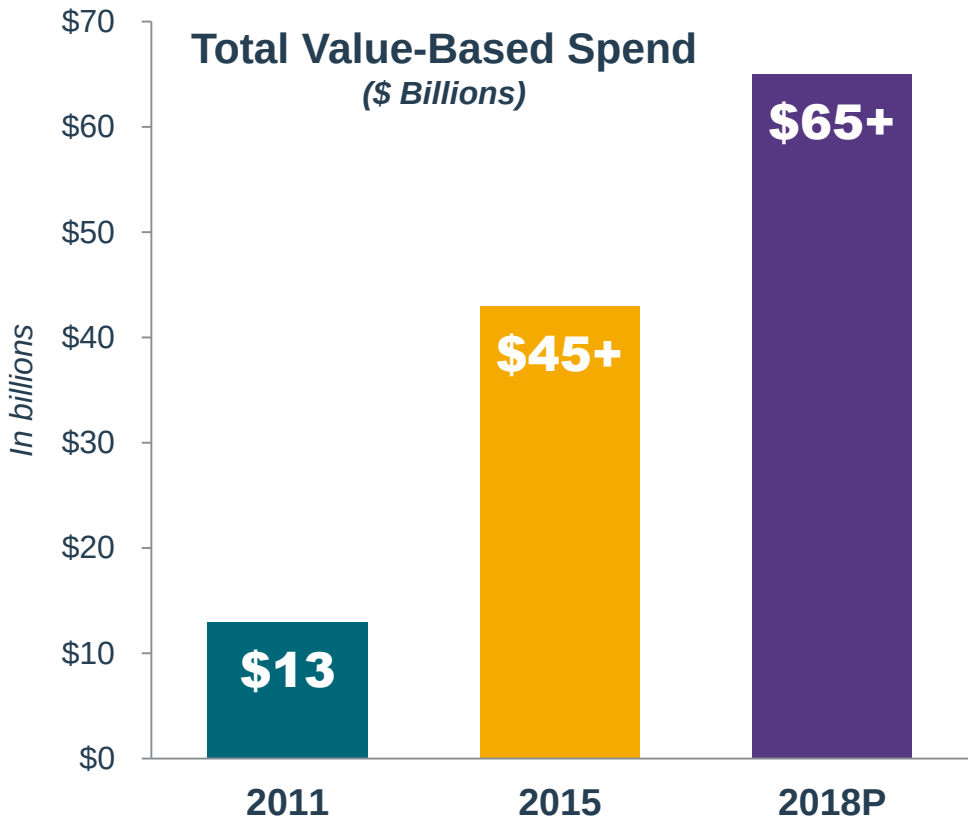
>13M

members impacted by value-based programs

1%-6%

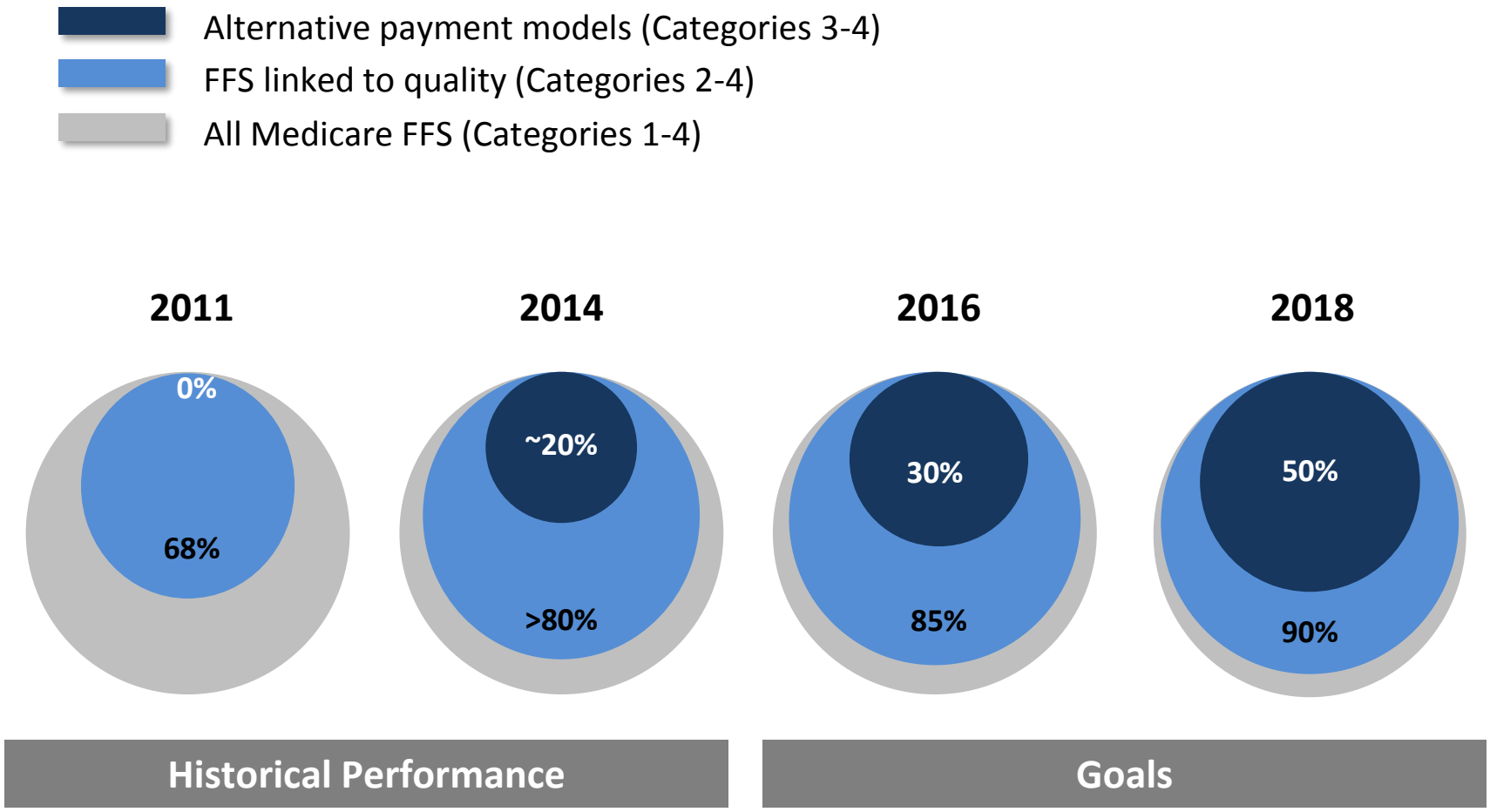
lower medical cost across a range of Value-Based Care Programs

Value-Based Contracting Growth



All figures are reflective of all lines of business and programs in aggregate.

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

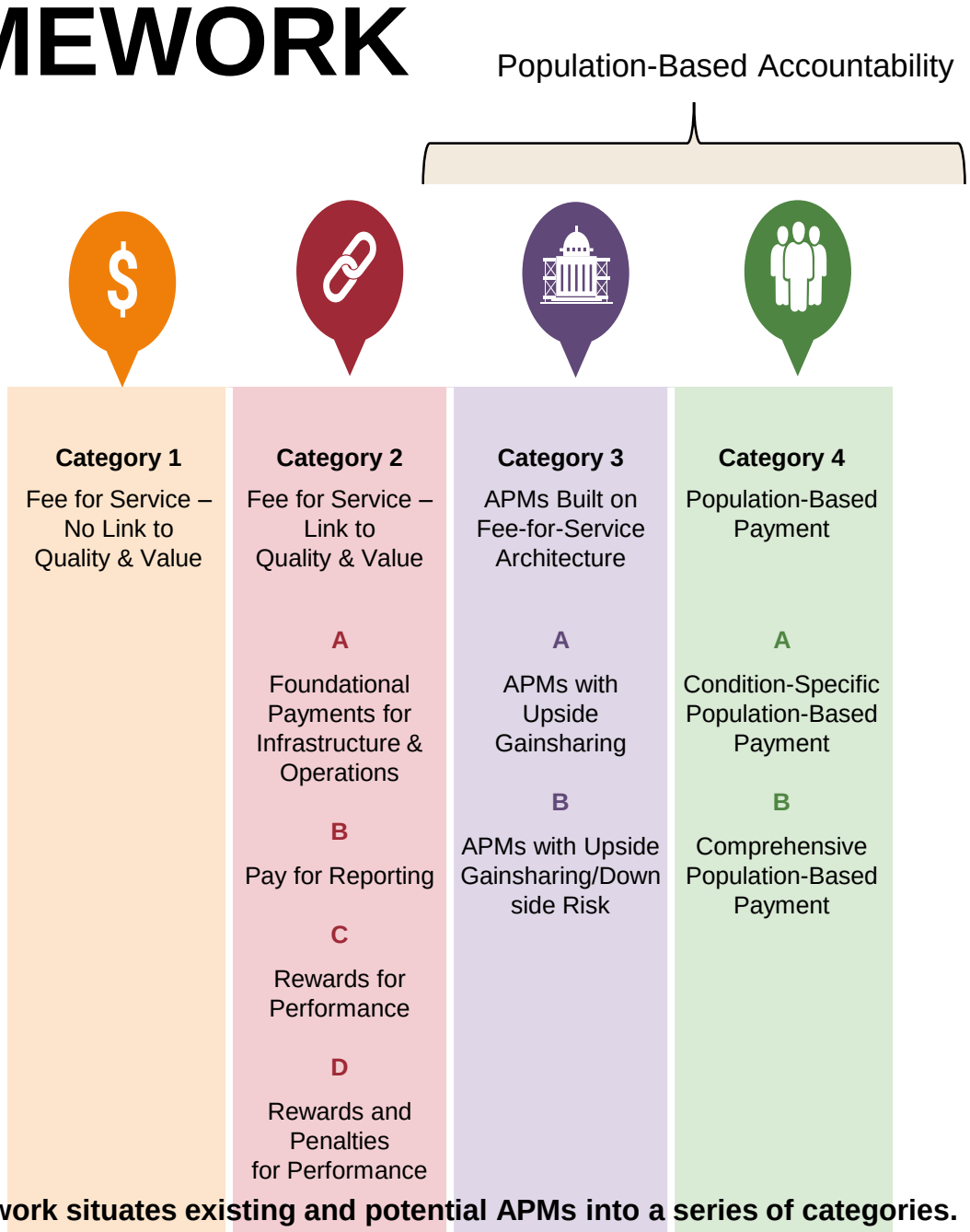


APM FRAMEWORK

At-a-Glance

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

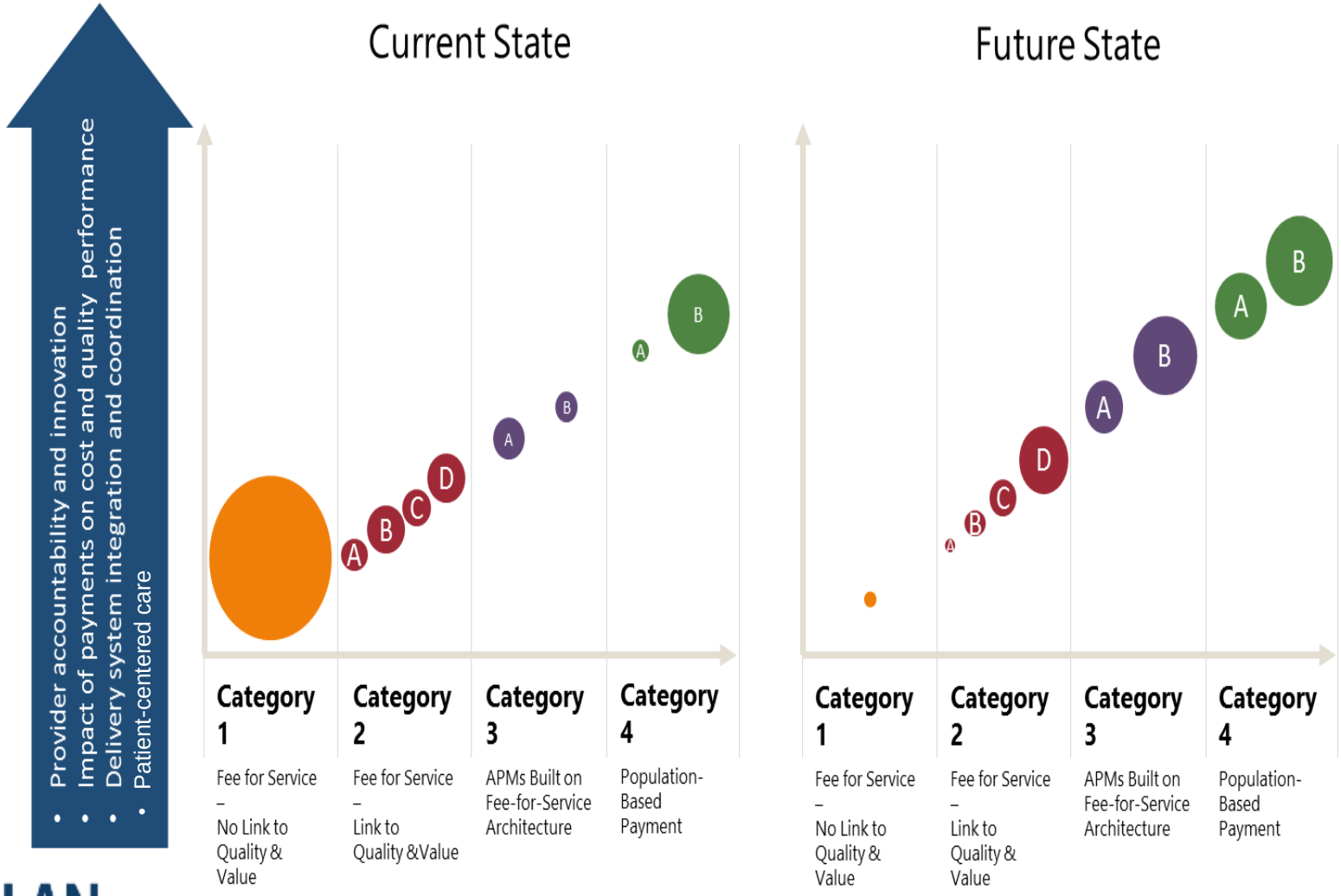
- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care
- **Acts as a "gauge" for measuring progress** toward adoption of alternative payment models
- **Establishes a common nomenclature and a set of conventions** that will facilitate discussions within and across stakeholder communities



The framework situates existing and potential APMs into a series of categories.

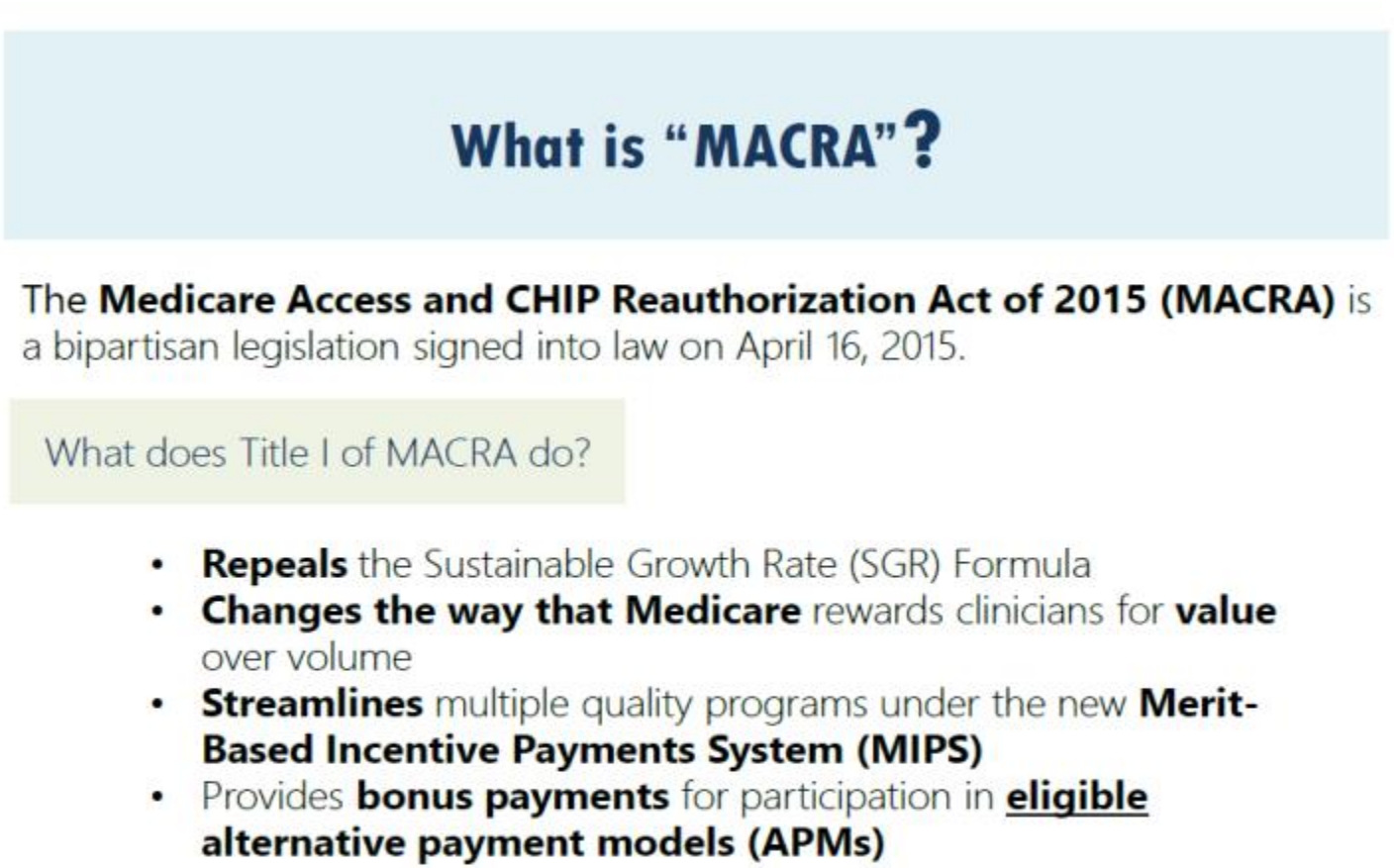
APM GOALS

For Payment Reform



HCP LAN
Health Care Payment Learning & Action Network

MACRA: Overview



Source: https://www.lansummit.org/wp-content/uploads/sites/8/2015/09/4G-00Total.pdf

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MACRA: Paying for Value via MIPS or APMs

Executive Summary

On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the flawed Sustainable Growth Rate formula with a new approach to paying clinicians for the value and quality of care they provide.

The proposed rule would implement these changes through the unified framework called the "Quality Payment Program," which includes two paths:

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

Source: CMS NPRM Quality Payment Program Summary

MACRA: MIPS Overview

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program **(PQRS)**
- Value-Based Payment Modifier
- Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

Merit-Based Incentive Payment System **(MIPS)**

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MACRA: MIPS Scoring

How will physicians and practitioners be scored under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

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MACRA: MIPS Scoring Categories

Table 1 below summarizes the categories of MIPS as proposed.

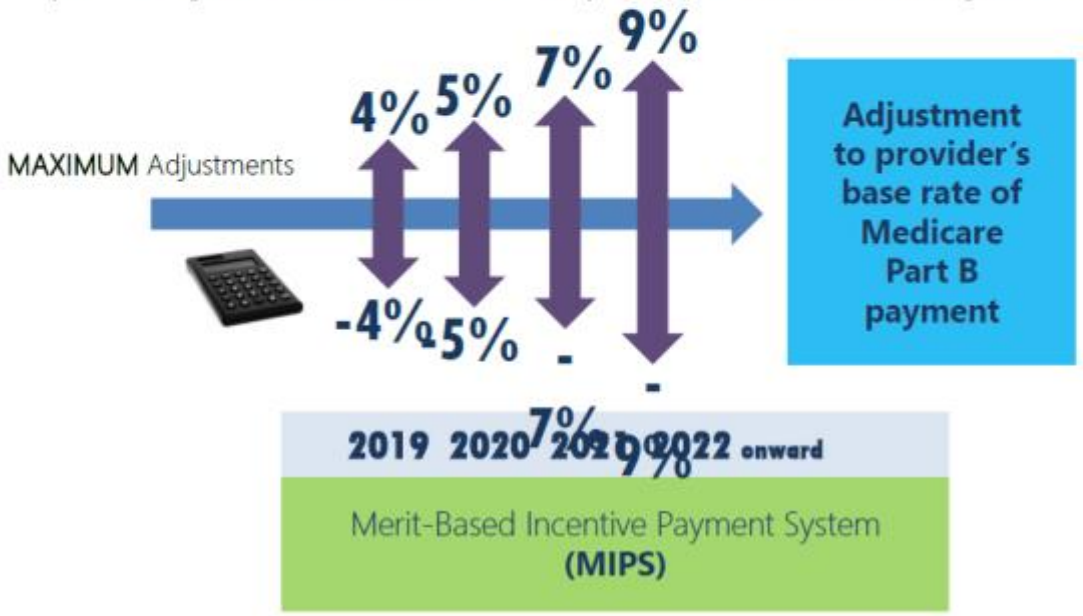
Table 1: Summary of MIPS Performance Categories

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource measures that can be attributed.	10 percent

MACRA: MIPS Payment Adjustments

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.



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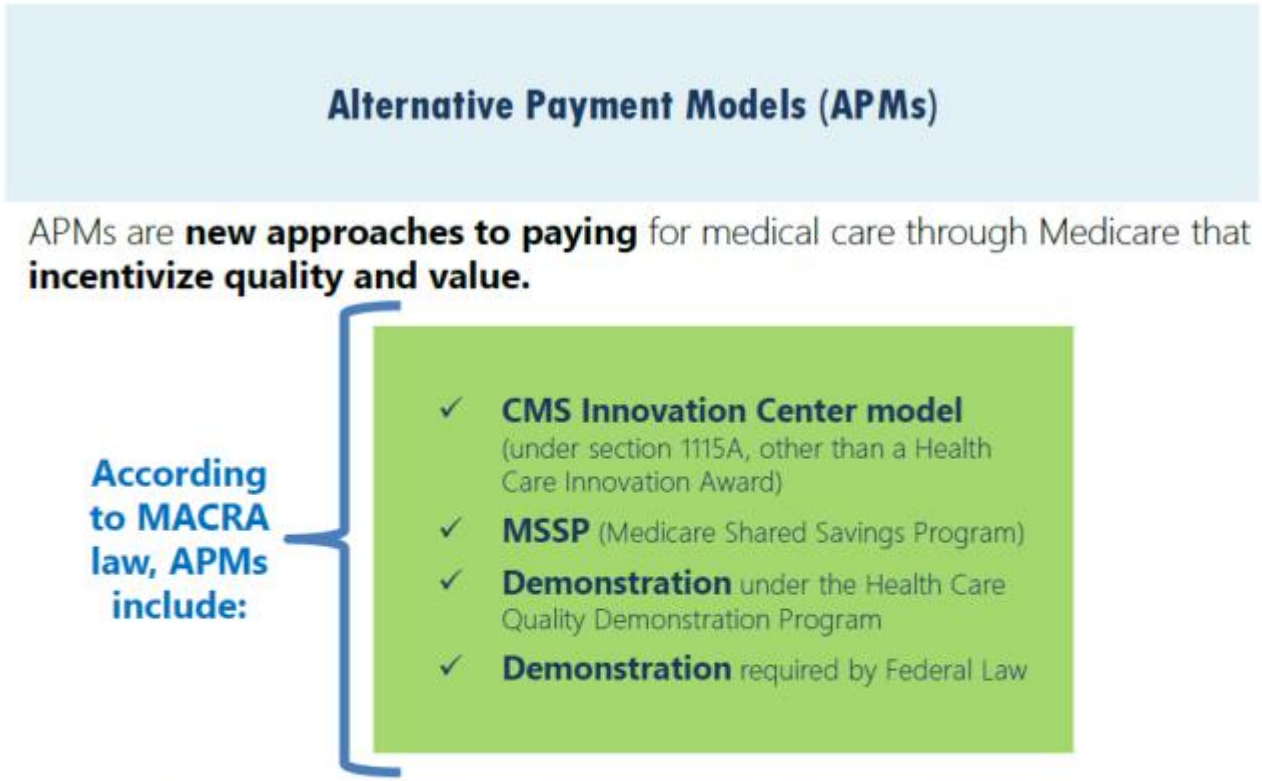
MACRA: APMs



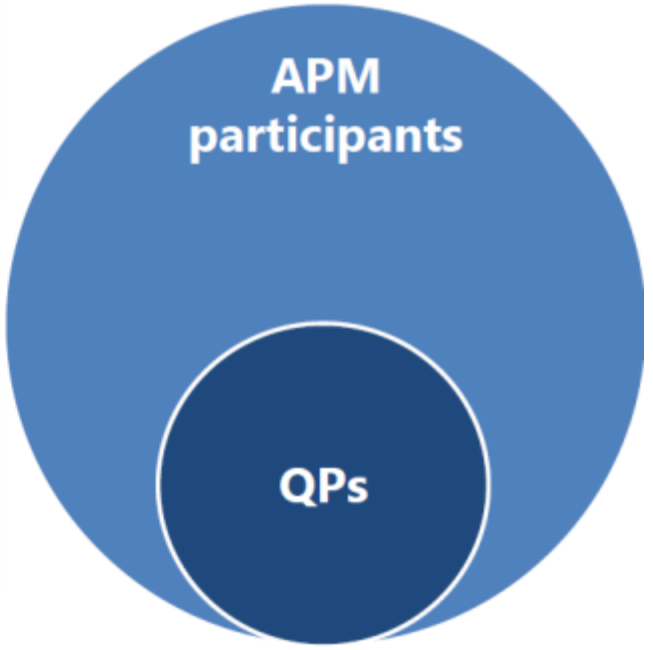
MACRA: Paying for Value via APMs

How does MACRA provide additional rewards for participation in APMs?

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive **favorable scoring** under the MIPS clinical practice improvement activities performance category.

Those who participate in **the most advanced** APMs may be determined to be **qualifying APM participants ("QPs")**. As a result, QPs:

1. Are **not subject** to MIPS
2. Receive 5% lump sum **bonus payments** for years 2019-2024
3. Receive a **higher fee schedule update** for 2026 and onward



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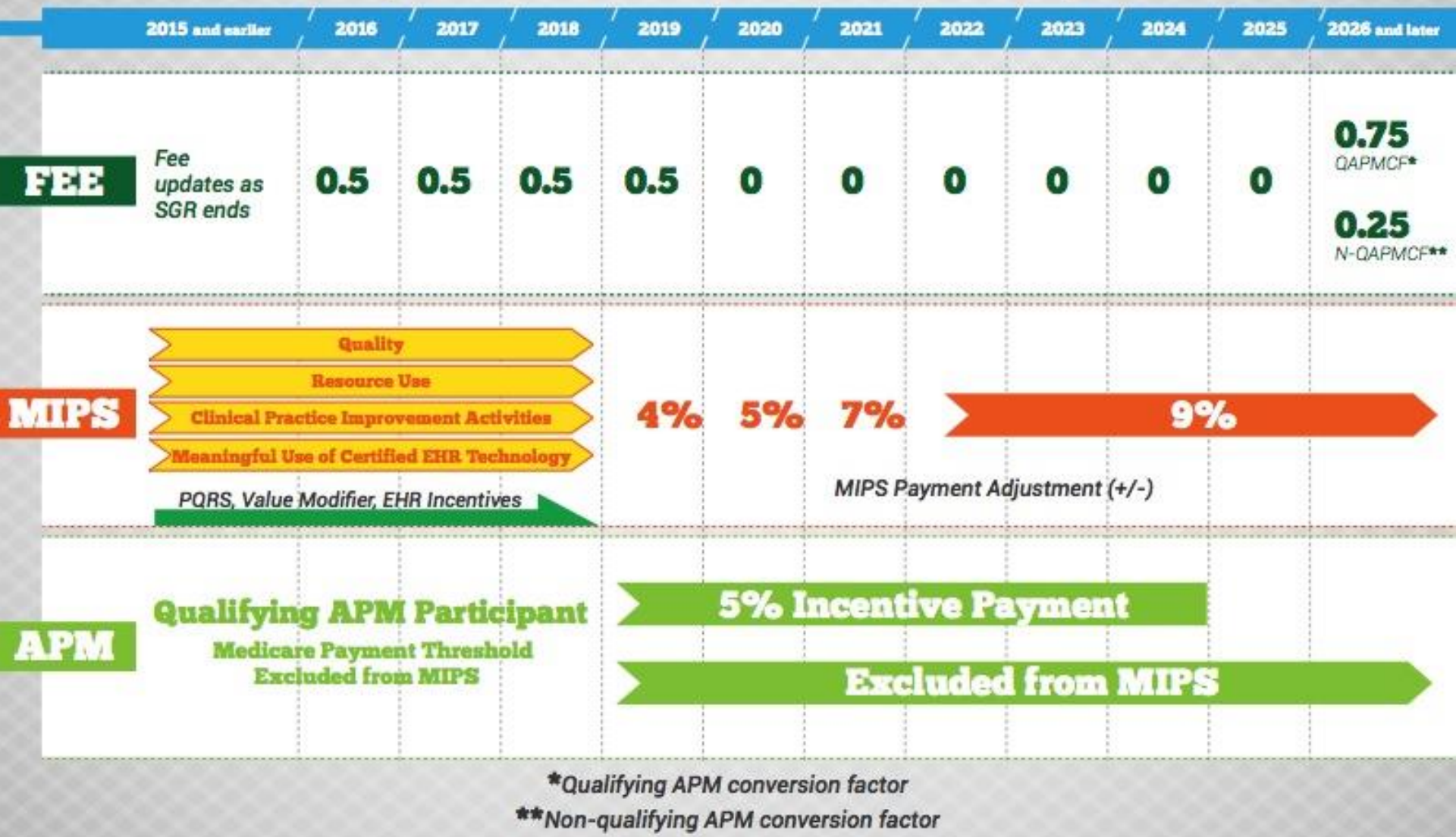
Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

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THANK YOU!
Questions/Discussion