The Merit-based Incentive Payment System (MIPS): A Detailed Overview of the Proposed Rule

Jeffrey R. Coughlin, MPP

May 25, 2016
Learning Objectives

• Identify the background and purpose of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• Review the provisions of the proposed regulation

• Examine the regulatory and business impact on clinicians
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ACI</td>
<td>Advancing Care Information</td>
</tr>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
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<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
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<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
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<tr>
<td>CEHRT</td>
<td>Certified EHR Technology</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CPIA</td>
<td>Clinical Practice Improvement Activities</td>
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<td>CQM</td>
<td>Clinical Quality Measure</td>
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<tr>
<td>EH</td>
<td>Eligible Hospital</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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## Abbreviations

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<tbody>
<tr>
<td>EP</td>
<td>Eligible Provider</td>
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<tr>
<td>ESRD</td>
<td>End-Stage Renal Disease</td>
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<tr>
<td>FFS</td>
<td>Fee-for-service</td>
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<tr>
<td>LDO</td>
<td>Large Dialysis Organization</td>
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<tr>
<td>MACRA</td>
<td>Medicare Access &amp; CHIP Reauthorization Act of 2015</td>
</tr>
<tr>
<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
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<tr>
<td>MSSP</td>
<td>Medicare Shared Savings Program</td>
</tr>
<tr>
<td>MU</td>
<td>Meaningful Use</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<td>NPRM</td>
<td>Notice of Proposed Rulemaking</td>
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## Abbreviations

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<tr>
<td>OCM</td>
<td>Oncology Care Model</td>
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<td>ONC</td>
<td>Office of the National Coordinator for Health IT</td>
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<td>PFS</td>
<td>Physician Fee Schedule</td>
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<td>PQRS</td>
<td>Physician Quality Reporting System</td>
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<tr>
<td>QCDR</td>
<td>Qualified Clinical Data Registry</td>
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<tr>
<td>QP</td>
<td>Qualifying APM Participant</td>
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<td>QPP</td>
<td>Quality Payment Program</td>
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<td>SGR</td>
<td>Sustainable Growth Rate</td>
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<tr>
<td>VM</td>
<td>Value-based Payment Modifier</td>
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Agenda

- Setting the Stage on Value-Based Care
- Background on MACRA
- Merit-Based Incentive Payment System (MIPS) Track
- Scoring of the MIPS Track
- MU-Related Provisions in the MACRA Rule
- Open Questions from the Proposed Rule
- Next Steps
- Q&A
Setting the Stage on Value-Based Care
Delivery System Reform will result in better care, smarter spending, and healthier people.

<table>
<thead>
<tr>
<th>Historical state</th>
<th>Evolving future state</th>
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<tr>
<td>Public and Private Sectors</td>
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</table>

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Fee-For-Service Payment Systems

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Graphic courtesy of the Centers for Medicare & Medicaid Services
In January 2015, HHS Announced Goals for Medicare Value-Based and Quality-Related Payments

**Medicare Fee-for-Service**

**GOAL 1:** 30%

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:** 85%

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

**STAKEHOLDERS:**

- Consumers
- Businesses
- Payers
- Providers
- State Partners

**Graphic courtesy of the Centers for Medicare & Medicaid Services**
The Medicare Access & CHIP Reauthorization Act of 2015

• Passed into law April 2015
• Repeals the SGR Formula
• Streamlines multiple quality reporting programs into a Merit-based Incentive Payment System (MIPS) – a goal is to decrease clinician burden
• Incentive payments for participating in Advanced Alternative Payment Models (APMs)
• Sustain Medicare by paying for what works
MACRA and Healthcare Transformation

• Requires CMS to change how Medicare rewards clinicians -- **value** over volume

• Merit-Based Incentive Payment System (MIPS)
  – Streamlines PQRS, VM, and MU programs to work as one, adding flexibility
  – Adds a fourth component to promote and reward practice improvement and innovation

• **Bonus payments** for participation in **Advanced Alternative Payment Models (APMs)**
MACRA Focus: The Medicare Clinician Community

- MACRA Proposed Rule focuses on clinicians who bill Medicare for Part B Services
  - No direct impact on hospitals or Medicaid providers
- Proposed Rule also includes modifications to the Meaningful Use (MU) Program
  - Impacts all Medicare MU Eligible Professionals, Eligible Hospitals and Critical Access Hospitals
MACRA Creates Two Tracks for Providers

Providers Must Choose either MIPS or APM Track, not both

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

- **2015 – 2019:** 0.5% annual update
- **2018:** Last year of separate MU, PQRS, and VBM penalties
- **2019:** Combine PQRS, MU, & VBM programs: -4% to +12% at risk
- **2020 – 2025:** Frozen payment rates
- **2020:** -5% to +15% at risk
- **2022 and on:** -9% to +27% at risk

**Advanced Alternative Payment Models (APMs)**

- **2015 – 2019:** 0.5% annual update
- **2019 - 2024:** 5% participation bonus
- **2019 - 2020:** 25% Medicare revenue requirement
- **2021 and on:** Ramped up Medicare or all-payer revenue requirements

2020:
- 5% to +15% at risk

2021:
- -7% to +21% at risk

2022 and on:
- -9% to +27% at risk

2026 and on:
- 0.25% annual update

2026 and on:
- 0.75% annual update

*Slide courtesy of the Centers for Medicare & Medicaid Services*
The Merit-Based Incentive Payment System (MIPS) Track
MIPS Performance Categories

Quality  Resource use  Clinical practice improvement activities  Advancing care information

MIPS Composite Performance Score (CPS)

Graphic courtesy of the Centers for Medicare & Medicaid Services
Defining MIPS Eligible Clinicians

• MIPS applies to Medicare Part B clinicians, including:
  – Physicians
  – Physician Assistants
  – Nurse Practitioners
  – Clinical Nurse Specialists
  – Certified Registered Nurse Anesthetists

• All Medicare Part B clinicians will report through MIPS during the first performance year
  – Proposed as a full year of reporting
  – Beginning in January 2017 for 2019 payment
Defining MIPS Eligible Clinicians

• In Performance Year 3 (2019) HHS Secretary has the option to expand MIPS participation to other types of clinicians, such as
  – Physical or Occupational Therapists
  – Speech-language Pathologists
  – Audiologists
  – Clinical Social Workers
  – Clinical Psychologists
Clinicians Can Choose to Participate Individually or a Group

• Clinicians will have the option to be assessed as a group across all four MIPS performance categories.

• Medicare Part B clinicians may be exempted from payment adjustment under MIPS if they
  – Are newly enrolled in Medicare
  – Have $10,000 or less in Medicare charges and 100 or fewer Medicare patients
  – Are significantly participating in an Advanced APM
Year 1 of the MIPS Program

- Clinical Practice Improvement: 15%
- Resource Use (Cost): 10%
- Advancing Care Information: 25%
- Quality: 50%
## Performance Category Weight Changes by Year—Proposed

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2019 MIPS Payment Year</th>
<th>2020 MIPS Payment Year</th>
<th>2021 MIPS Payment Year and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## MIPS Performance Category Scoring

<table>
<thead>
<tr>
<th>Quality</th>
<th>Maximum Points</th>
<th>Percentage of Overall MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians choose six measures to report to CMS that best reflect their practice.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent (Performance Year 1 - 2017)</td>
</tr>
<tr>
<td>• One must be an outcome measure or a high-priority measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One must be a cross-cutting measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinicians also can choose to report a specialty measure set</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**CMS is Striving to Include Core Quality Measures that Private Payers Already Use**

- Clinicians would choose 6 measures to report out of a possible 200
  - More than 80% of the quality measures proposed are tailored for specialists

- MIPS also calculates population measures based on claims data to also reduce the reporting burden
  - For individual clinicians and small groups, MIPS calculates two population measures
  - For groups with 10 clinicians or more, MIPS calculates three population measures
## Required Quality Measure Types: Examples

<table>
<thead>
<tr>
<th>Quality Measure Type</th>
<th>Examples (from NPRM Appendix Tables A-D)</th>
</tr>
</thead>
</table>
| **Outcome Measure (TABLES A–E)**                        | • Coronary Artery Bypass Graft (CABG): Stroke  
• Functional Status Change for Patients with Knee Impairments  
• Controlling High Blood Pressure                                                                                                                                                                    |
| **High Priority Measure (TABLES A–D)**                  | Outcome, Appropriate Use, Patient Safety, Efficiency, Patient Experience, Care Coordination  
• Diabetes: Hemoglobin A1c (HbA1c) Poor Control  
• Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)                                                                                                                                   |
| **Cross-cutting Measure (TABLE C)**                      | • Documentation of Current Meds  
• Preventive Care and Screening: Tobacco Use                                                                                                                                                                                                                  |
| **Specialty Measure Set (TABLE E)**                      | Gastroenterology  
• Colorectal Cancer Screening  
• Colonoscopy Interval for Patients with a History of Adenomatous Polyps                                                                                                                                   |
MIPS Makes Specialty Measure Sets Available

- Allergy/Immunology/Rheumatology
- Anesthesiology
- Cardiology
- Gastroenterology
- Dermatology
- Emergency Medicine
- General Practice/Family Medicine
- Internal Medicine
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery

- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Preventative Medicine
- Neurology
- Mental/Behavioral Health
- Radiology
- Surgery
- Thoracic Surgery
- Urology
# MIPS Performance Category Scoring

<table>
<thead>
<tr>
<th>Clinical Practice Improvement</th>
<th>Maximum Points</th>
<th>Percentage of Overall MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 90 activities from which to choose</td>
<td>60 points</td>
<td>15 percent (Performance Year 1 - 2017)</td>
</tr>
<tr>
<td>Clinicians can choose the activities best suited for their practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinicians participating in medical homes earn “full credit” in this category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants in Advanced APMs will earn at least half credit</td>
<td></td>
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</tr>
</tbody>
</table>
Clinical Practice Improvement Activities Account for 15% of the MIPS Score

• MIPS would reward CPIA focused on care coordination, beneficiary engagement, and patient safety

• CMS proposes to determine a clinicians’ score by weighting the activities on which they report
  – Highly weighted activities would be worth 20 points, and others worth 10 points
  – Examples of highly weighted activities include
    • Support patient-centered medical homes
    • Activities that support the transformation of clinical practice or a public health priority
### MIPS Performance Category Scoring

#### Resource Use

<table>
<thead>
<tr>
<th>Maximum Points</th>
<th>Percentage of Overall MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent (Performance Year 1 - 2017)</td>
</tr>
</tbody>
</table>

- CMS will calculate these measures based on claims and availability of sufficient volume.
- Clinicians do not need to report anything.
The Cost Category Replaces the VM Program

- MIPS calculates scores based on Medicare claims, meaning there are no additional reporting requirements.
- Sufficient number of patients required for each cost measure to be scored:
  - Generally a minimum of a 20-patient sample
- The cost score would be calculated based on the average score of all the cost measures attributed.
- If no patient volume, cost category would be reweighted to zero, and the other MIPS categories would be adjusted to make up the difference in the MIPS score.
## MIPS Performance Category Scoring

**Advancing Care Information**

<table>
<thead>
<tr>
<th>Maximum Points</th>
<th>Percentage of Overall MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 points</td>
<td>25 percent (Performance Year 1 - 2017)</td>
</tr>
</tbody>
</table>

- Clinicians will report key measures of interoperability and information exchange.
- Clinicians are rewarded for their performance on measures that matter most to them.
Advancing Care Information has a Maximum Score of 100 Points

Makes up to 50 points of the total Advancing Care Information Performance Category Score

Makes up to 80 points of the total Advancing Care Information Performance Category Score

Up to 1 point of the total Advancing Care Information Performance Category Score

Earn 100 or more points and receive FULL 25 points in the Advancing Care Information Category of MIPS Composite Score

Courtesy of the Centers for Medicare & Medicaid Services
# Changes to Meaningful Use in MACRA NPRM

<table>
<thead>
<tr>
<th>Meaningful Use</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must report on all objective and measure requirements</td>
<td>• Streamlines measures&lt;br&gt;• Emphasizes interoperability, information exchange, and security measures&lt;br&gt;• Reporting on Clinical Decision Support and Computerized Provider Order Entry no longer required</td>
</tr>
<tr>
<td>One-size-fits-all—every measure reported and weighed equally</td>
<td>• Customizable—Physicians or clinicians can choose which best measures fit their practice</td>
</tr>
<tr>
<td>All-or-nothing EHR measurement and quality reporting</td>
<td>• Flexible—multiple paths to success</td>
</tr>
<tr>
<td>Misaligned with other Medicare reporting programs</td>
<td>• Aligned with other Medicare reporting programs&lt;br&gt;• No need to report quality measures as part of this category</td>
</tr>
</tbody>
</table>
The Advancing Care Information Category Base Score

• Dropped “all or nothing” scoring for measurement

• Overall, six objectives and their measures that would require reporting
  – Four Numerator/Denominator Dependent
    • Patient Electronic Access
    • Coordination of Care Through Patient Engagement
    • Electronic Prescribing
    • Health Information Exchange
Additional Information on the Advancing Care Information Category Base Score

• Two additional objectives and their measures that would require reporting
  – Require a Yes/No Answer
    • Protect Patient Health Information
    • Public Health and Clinical Data Registry Reporting

• To earn any score in the Advancing Care Information performance category, a clinician would need to meet the requirement to protect patient health information created or maintained by CEHRT
The Advancing Care Information Category Performance Score

• Clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:
  – Patient Electronic Access
  – Coordination of Care Through Patient Engagement
  – Health Information Exchange

• If a physician or other clinician only has data for a portion of the year, the proposal would allow the clinician to still participate in this category
Bonus Point Available For Additional Registry Reporting

• Although immunization registry reporting is required, if clinicians choose to report to other public health registries, they will receive one additional point for reporting beyond the immunization category

• Beginning in 2017, clinicians who currently participate in the Medicare EHR Incentive Program will no longer report or attest for this program and will instead report through MIPS
ECs can use EHR Technology Certified to Either 2014 or 2015 Certification Criteria in 2017

- The objectives and measures specified for ACI are dependent on which certification criteria you use
- ECs can use a combination of the 2014 and 2015 Edition
  - ECs that only have technology certified to the 2014 Edition would not be able to report on any measures that correlate to MU Stage 3
- For the 2018 performance period, ECs can only use technology certified to the 2015 Edition
## Flexible Data Submission Mechanisms for Individuals and Groups

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Individual Reporting</th>
<th>Group Practice Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Claims</td>
<td>• QCDR</td>
</tr>
<tr>
<td></td>
<td>• Qualified Clinical Data Registries (QCDRs)</td>
<td>• Qualified registry</td>
</tr>
<tr>
<td></td>
<td>• Qualified registry</td>
<td>• EHR</td>
</tr>
<tr>
<td></td>
<td>• EHR</td>
<td>• CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td>• Administrative claims (no submission required)</td>
<td>(groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMS-approved survey vendor for CAHPS for MIPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Administrative claims (no submission required)</td>
</tr>
<tr>
<td>Resource Use</td>
<td>• Administrative claims (no submission required)</td>
<td>• Administrative claims (no submission required)</td>
</tr>
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</tr>
</tbody>
</table>
# Flexible Data Submission Mechanisms for Individuals and Groups

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Individual Reporting</th>
<th>Group Practice Reporting</th>
</tr>
</thead>
</table>
| Advancing Care Information | • Attestation  
• QCDR  
• Qualified registry  
• EHR | • Attestation  
• QCDR  
• Qualified registry  
• EHR  
• CMS Web Interface (groups of 25 or more) |
| CPIA | • Attestation  
• QCDR  
• Qualified registry  
• EHR  
• Administrative claims | • Attestation  
• QCDR  
• Qualified registry  
• EHR  
• CMS Web Interface (groups of 25 or more)  
• Administrative claims |
Scoring of the MIPS Track
MIPS Creates a Composite Score Based on each Performance Category

- Clinicians’ MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments
  - The aggregated MIPS composite performance score would be compared against a MIPS performance threshold
  - CMS updates threshold on an annual basis
In Year 1, Negative Adjustments Not to Exceed 4%

• Depending on variation in MIPS scores, adjustments are calculated so that negative adjustments are capped at -4%

• Positive adjustments are generally up to 4%
  – Scaled up or down to achieve budget neutrality
  – Could be lower or higher than 4%
Adjustments Continue to Increase Over Time

• Negative adjustments and positive adjustments increase over time

• In the first five payment years, $500 million in additional performance bonuses for exceptional performance will be available (exempt from budget neutrality)
  – Provides high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent
### MIPS Payment Adjustments (Positive and Negative)

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</thead>
<tbody>
<tr>
<td>PQRS+VM+ EHR Incentive Penalties (combined)</td>
<td>-4.5%</td>
<td>-6.0%</td>
<td>-9.0%</td>
<td>-10% or more</td>
<td>-11% or more</td>
<td>-11% or more</td>
<td>-11% or more</td>
<td>-11% or more</td>
</tr>
<tr>
<td>MIPS Bonus/Penalty (max)</td>
<td>-4.5%</td>
<td>-6.0%</td>
<td>-9.0%</td>
<td>-10% or more</td>
<td>+4%*</td>
<td>+5%*</td>
<td>+7%*</td>
<td>+9%*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-4%</td>
<td>-5%</td>
<td>-7%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

* May be increased by up to 3 times to incentivize performance

$500 mil funding for bonuses allocated through 2024
MU-Related Provisions in the MACRA Rule
Additional Requirements in MACRA NPRM for All MU Providers

- CMS is adding two requirements for certified EHR technology to the attestation requirements under MU, the ACI performance category score under MIPS, and reporting under the APM track.

<table>
<thead>
<tr>
<th>New Requirements for ACI Clinicians and All MU Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers must attest that they have cooperated with the authorized ONC surveillance of Certified EHR Technology under the ONC Health IT Certification Program</td>
</tr>
</tbody>
</table>
Reducing Physician Burden is a Consideration for the Surveillance Attestation

Cooperation on this attestation would include the following points:

- Responding in a timely manner and in good faith to RFIs about the performance of the CEHRT technology capabilities

- Accommodating requests for access to the provider’s CEHRT as deployed by the provider in its production environment for the purpose of carrying out authorized surveillance or direct review
  
  - The data stored in CEHRT is also included in this review
Three-Part Attestation for HIE Requirements

Providers must attest to the following points

• Not knowingly and willfully taking actions to limit or restrict the compatibility or interoperability of CEHRT

• Implementing technologies, standards, policies, practices, and agreements reasonably calculated to ensure that CEHRT was connected, compliant, and implemented in a manner that allowed for timely access by patients

• Responding in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients and other providers
  – Regardless of the requestor’s affiliation or technology vendor
Open Questions from the Proposed Rule
Open Questions From MACRA Proposed Rule

• Full-year reporting year in 2017
  – Possibility of partial-year reporting?

• Overall complexity

• Reporting burden

• Attestation to surveillance/exchange Provisions

• Feedback loop for clinicians from CMS
Estimates on Clinician Participation in MIPS

• MIPS would distribute payment adjustments to between approximately 687,000 and 746,000 ECs in 2019
  – Equally distributed between negative adjustments ($833 million) and positive adjustments ($833 million) to MIPS ECs, to ensure budget neutrality

• For APMs, 30,658 and 90,000 ECs would become qualifying providers through participation in Advanced APMs
  – APM Incentive Payments for CY 2019 of between $146 million and $429 million
## Estimated MIPS Impact on Total Allowed Charges by Practice Size

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Eligible Clinicians</th>
<th>Aggregate Impact Negative Payment Adjustment ($Mil)</th>
<th>Aggregate Impact Positive Adjustment ($Mil)</th>
<th>Aggregate Positive Adjustment, exceptional Performance Payment only ($Mil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>-$300</td>
<td>$105</td>
<td>$65</td>
</tr>
<tr>
<td>2-9 eligible clinicians</td>
<td>123,695</td>
<td>-$279</td>
<td>$295</td>
<td>$182</td>
</tr>
<tr>
<td>10-24 eligible clinicians</td>
<td>81,207</td>
<td>-$101</td>
<td>$164</td>
<td>$103</td>
</tr>
<tr>
<td>25-99 eligible clinicians</td>
<td>147,976</td>
<td>-$95</td>
<td>$230</td>
<td>$147</td>
</tr>
<tr>
<td>100 or more clinicians</td>
<td>305,676</td>
<td>-$57</td>
<td>$539</td>
<td>$336</td>
</tr>
<tr>
<td>Overall</td>
<td>761,342</td>
<td>-$833</td>
<td>$1,333</td>
<td>$833</td>
</tr>
</tbody>
</table>

2014 data used to estimate 2017 performance. Payments estimated using 2014 dollars
As a Medicare Clinician, what are my Options under MACRA?

- Am I in an Advanced APM?
  - Yes
  - No

- Am I in an APM?
  - Yes
  - No

- Is this my first year in Medicare OR am I below the low-volume threshold?
  - Yes
  - No

- Do I have enough payments or patients through my Advanced APM?
  - Yes
  - No

- Favorable MIPS scoring & APM-specific rewards

Qualifying APM Participant (QP)

- Excluded from MIPS
- 5% lump sum bonus payment (2019-2024), higher fee schedule updates (2026+)
- APM-specific rewards

Bottom line: There will be financial incentives for participating in an APM, even if you don’t become a QP.

Slide courtesy of the Centers for Medicare & Medicaid Services
Please Submit Questions Through the Chat Box
Join Us on June 1 for an APM Webinar

• HIMSS is hosting one additional MACRA webinar
  
  – June 1, 2016, 1:00 - 2:00 pm EDT  Advanced Alternative Payment Models (APMs): A Detailed Overview of the Proposed Rule

• Sign up for the webinar at the HIMSS Learning Center: http://www.himss.org/health-it-education/learning-center
MACRA Resources from HIMSS

• Visit the HIMSS MACRA Resource Center at http://www.himss.org/MACRA-resource-center

• Look to the Resource Center for Fact Sheets on specific MACRA topics, an executive summary, and a link to the MACRA proposed rule
Thank you for your participation