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Merit-Based Incentive Payment System Proposed Rule CY 2016

June 1, 2016

Slides on the Proposed Rule Prepared by:

- Gayle Lee, galee@aamc.org
- Tanvi Mehta, tmehta@aamc.org
- Ivy Baer, ibaer@aamc.org

Analysis Slides Prepared by:

- Jake Langley, jake.langley@vizientinc.com
- Kathy Yue, kathy.yue@vizientinc.com

Agenda

1. Quality Payment Program (QPP)
2. Merit-based Incentive Payment System (MIPS) Overview
3. MIPS Eligibility
4. Identifiers and Data Submission
5. Performance Categories & Scoring
6. MIPS Reporting under APMs
7. Payment Adjustments
8. Other Topics Related to MIPS

“Tolerance of Uncertainty”

January 2015--HHS Goes BIG on Quality & Value

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Fact sheets

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Better Care. Smarter Spending. Healthier People: Why It Matters

Date	2015-01-26
Title	Better Care. Smarter Spending. Healthier People: Why It Matters
Contact	press@cms.hhs.gov

Better Care. Smarter Spending. Healthier People: Why It Matters

HHS's Ambitious Goals

Moving to Alternative Payment Models

- **By end of 2016**: tie 30 % of fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements
- **By end of 2018**: 50 % percent of payments to these models

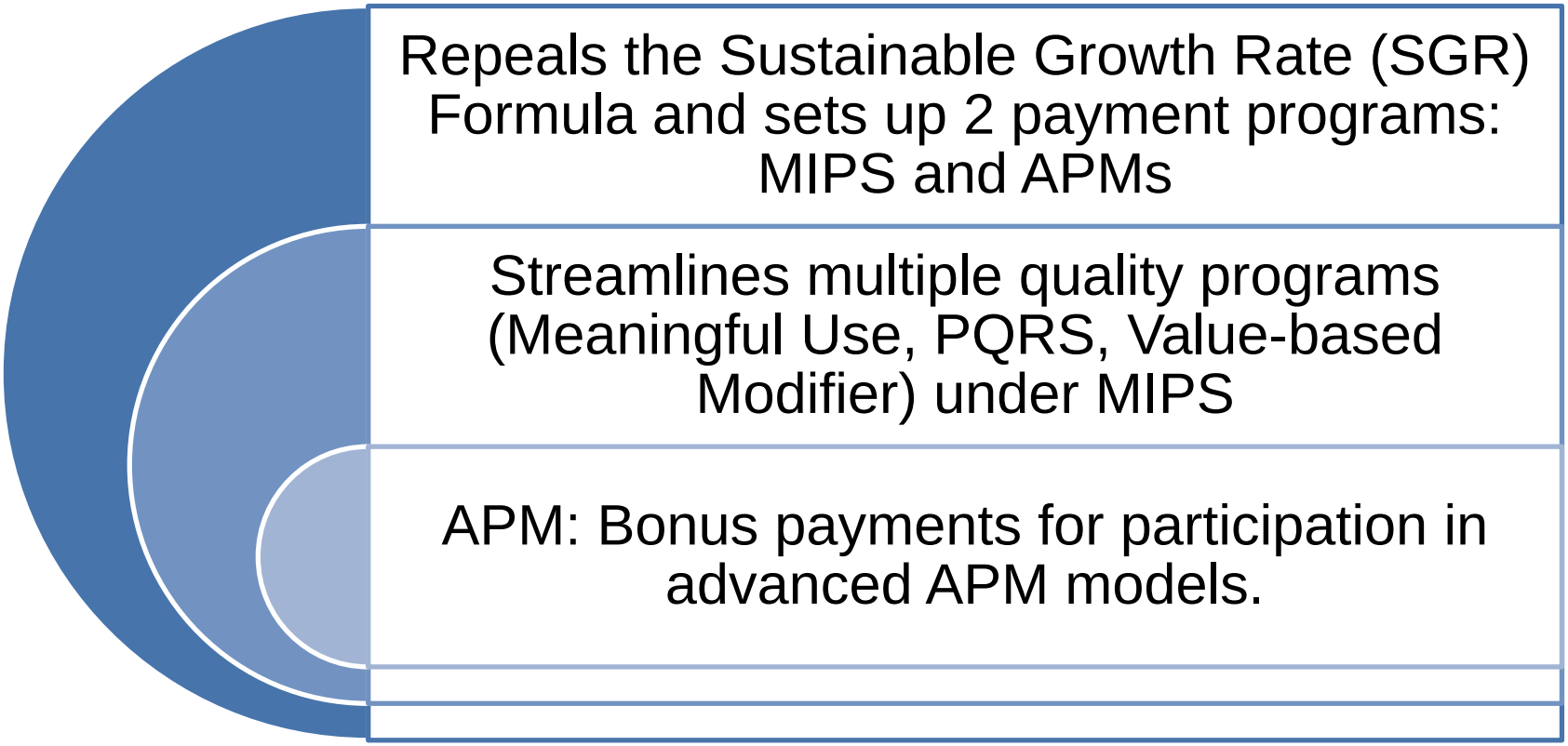
Moving traditional fee for service payment to:

- **2016**: tie 85% of payment to quality or value (HVBP, HRRP, e.g.)
- **2018:** move to 90%

April 2015: MACRA Is Enacted; MIPS/APMs Rule

The Current System: Volume Based	The Future State: Value Based
Provide a service, get paid.	Provide a service and your payment will vary depending on such factors as: • Meeting quality measures • Participating in alternative payment models • Being in a primary care medical home that meets the standards set out by the Center for Medicare and Medicaid Innovation (CMMI)
The more services you provide, the more revenue you get	Starting in 2019 (based on performance in 2017) payments will be linked to quality and value under a Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Model (APMs). Payment can be increased or decreased based on performance.

MACRA Legislation



Fee Schedule Remains Bedrock of Payment…

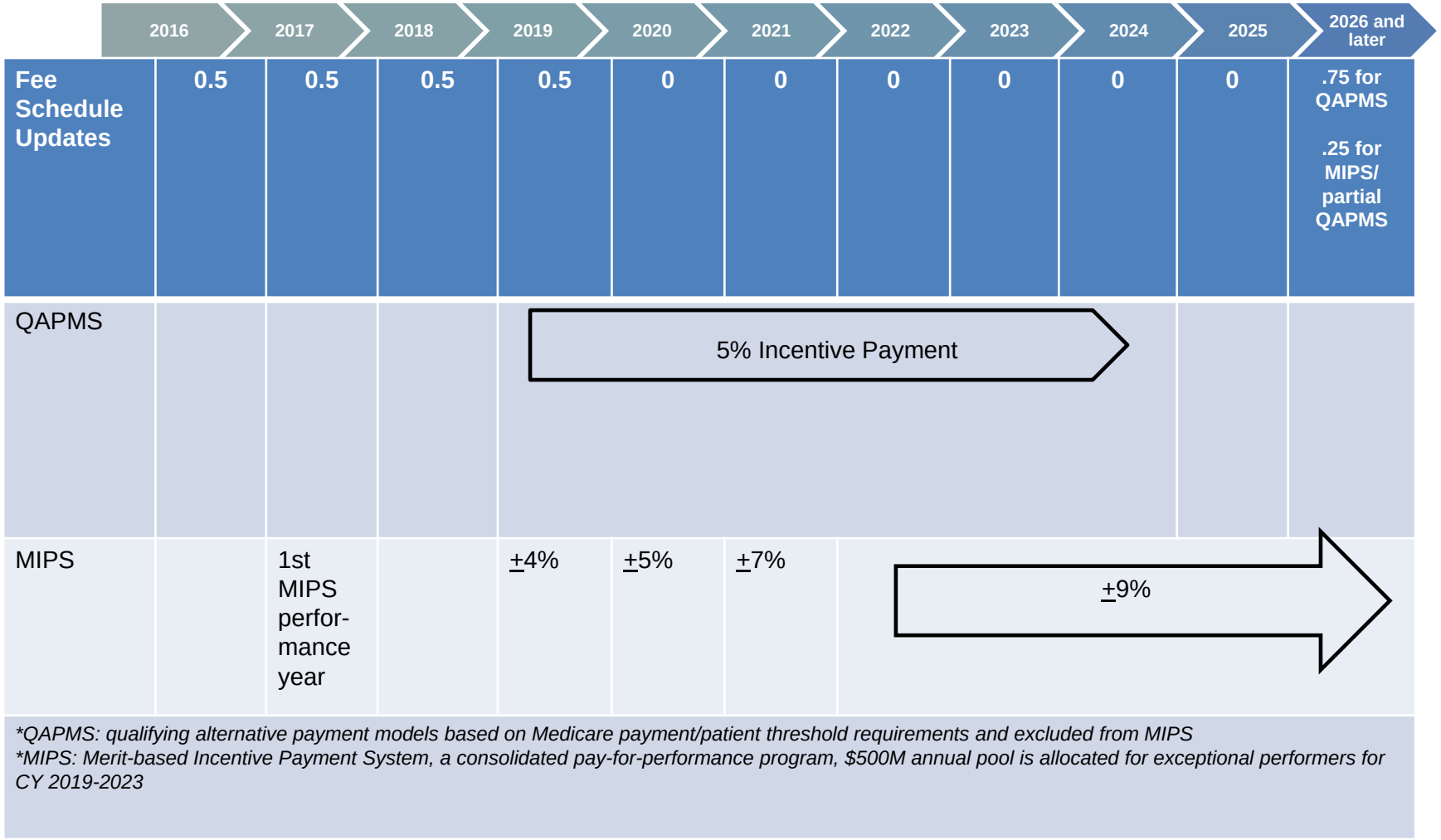
…What changes is how much you get paid and why

Timeline: How Much Payment is at Risk?

Potential Reductions	2015	2016	2017	2018	2019	2020	2021	2022
Medicare EHR Incentive	-1.0% or -2.0%[c]	-2.0%	-3.0%	Up to -4.0%[d]	--	--	--	--
PQRS	-1.5%	-2.0%	-2.0%	-2.0%	--	--	--	--
Value-modifier (Max reduction)[c]	-1.0%	-2.0%	-4.0%	-4.0%	--	--	--	--
MIPS	--	--	--	--	-4.0%	-5.0%	-7.0%	-9.0%
Total Possible Reduction	-4.5%	-6%	-9%	-10%	-4%	-5%	-7%	-9%

[c] Penalty increases to 2% if Eligible Clinician is subject to 2014 eRx penalty and Medicare EHR Incentive.
[d] AFTER 2017, the penalty increases by 1 percent per year (to a max of 5%) if min 75% of Eligible Clinicians are not participating; otherwise max is 3%

MACRA Timeline



QAPMS: qualifying alternative payment models based on Medicare payment/patient threshold requirements and excluded from MIPS
MIPS: Merit-based Incentive Payment System, a consolidated pay-for-performance program, $500M annual pool is allocated for exceptional performers for CY 2019-2023

MACRA Crossroads: Quality Payment Programs

MIPS

+/- 4% in 2019

+/-9% in 2022

CMS estimates 687,000-746,000 clinicians

APMs

+5% for 2019-2024

CMS estimates 30,658-90,000 Eligible Clinicians would become QPs

Placeholder for Polling Question #1

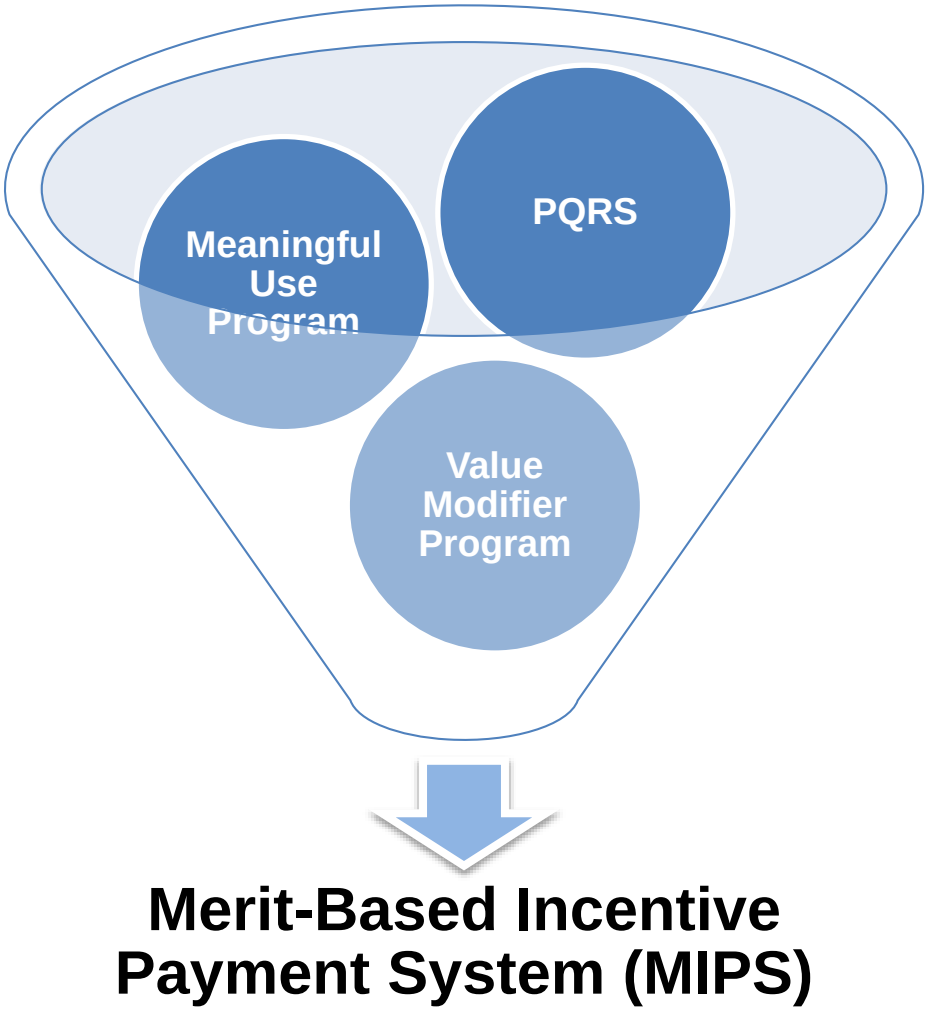
Are you participating or considering participating in one or more of the following models:

- Medicare Shared Savings Program-Track 2
- Medicare Shared Savings Program-Track 3
- Oncology Care Model 2-sided Risk
- Comprehensive Primary Care Initiative
- Next Generation ACO
- Other
- Not Applicable

MIPS Overview and Eligibility

Overview of MIPS

A New Consolidated Pay-for-Performance Program



Who Does MIPS Apply To?

Eligible Clinicians (starting in 2019)

- Physician
- Physician assistant (PA)
- Nurse practitioner (NP)
- Clinical nurse specialist
- CRNA

Starting **2021**, this category can be expanded: Proposed rule mentions OTs, PTs, clinical social workers

Exceptions to MIPS Participation for Certain Clinicians

Low Patient Volume

- Billing charges less than or equal to $10,000 and provider care for 100 or fewer Medicare patients in one year.

Participants in Advanced APMs

- Must meet threshold of Medicare payments or patients through Advanced APM to be qualifying APM participant or partial qualifying APM participant.

1st year clinician enrolled in Medicare program

- Not treated as MIPS eligible clinician until subsequent year

MIPS Identifiers and Reporting Mechanisms

Eligible Clinician Identifiers in MIPS: Two Options

Individuals

- Defined by Unique TIN/NPI
- Similar reporting mechanisms as current programs

Groups

- Defined by TIN
- Similar reporting mechanisms as current programs
- Also an option for MIPS/APM program

How to Identify as a Group Under MIPS

MIPS General	MIPS APM
• Single TIN of 2+ clinicians that have reassigned billing rights to the TIN • All MIPS eligible clinicians in group must use same TIN	• Unique APM identifier for each eligible clinician who is part of APM entity • Could include more than 1 TIN as long as the MIPS eligible clinicians identified as participants by unique APM participant identifiers • Not all eligible clinicians in TIN need to be APM participants • Must be APM participant on 12/31 of performance period

Data Submission Mechanisms: Individual Reporting

Performance Category	Individual Reporting
Quality	QCDR Qualified Registry EHR Administrative Claims (no submission required) Claims
Resource Use	Administrative Claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified Registry EHR
CPIA	Attestation QCDR Qualified Registry EHR Administrative claims (if technically feasible, no submission required)

Data Submission Mechanisms: Group Reporting

Performance Category	Group Reporting
Quality	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more) CMS-approved survey vendor for CAHPS for MIPS (must be reported with another data submission mechanism) Administrative Claims (no submission required) Claims
Resource Use	Administrative Claims (no submission required)
Advancing Care Information	Attestation QCDR Qualified registry EHR CMS Web Interface (groups of 25 or more)
CPIA	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more) Administrative Claims if feasible

Placeholder for Polling Question #2

What mechanism are you currently using for reporting PQRS?

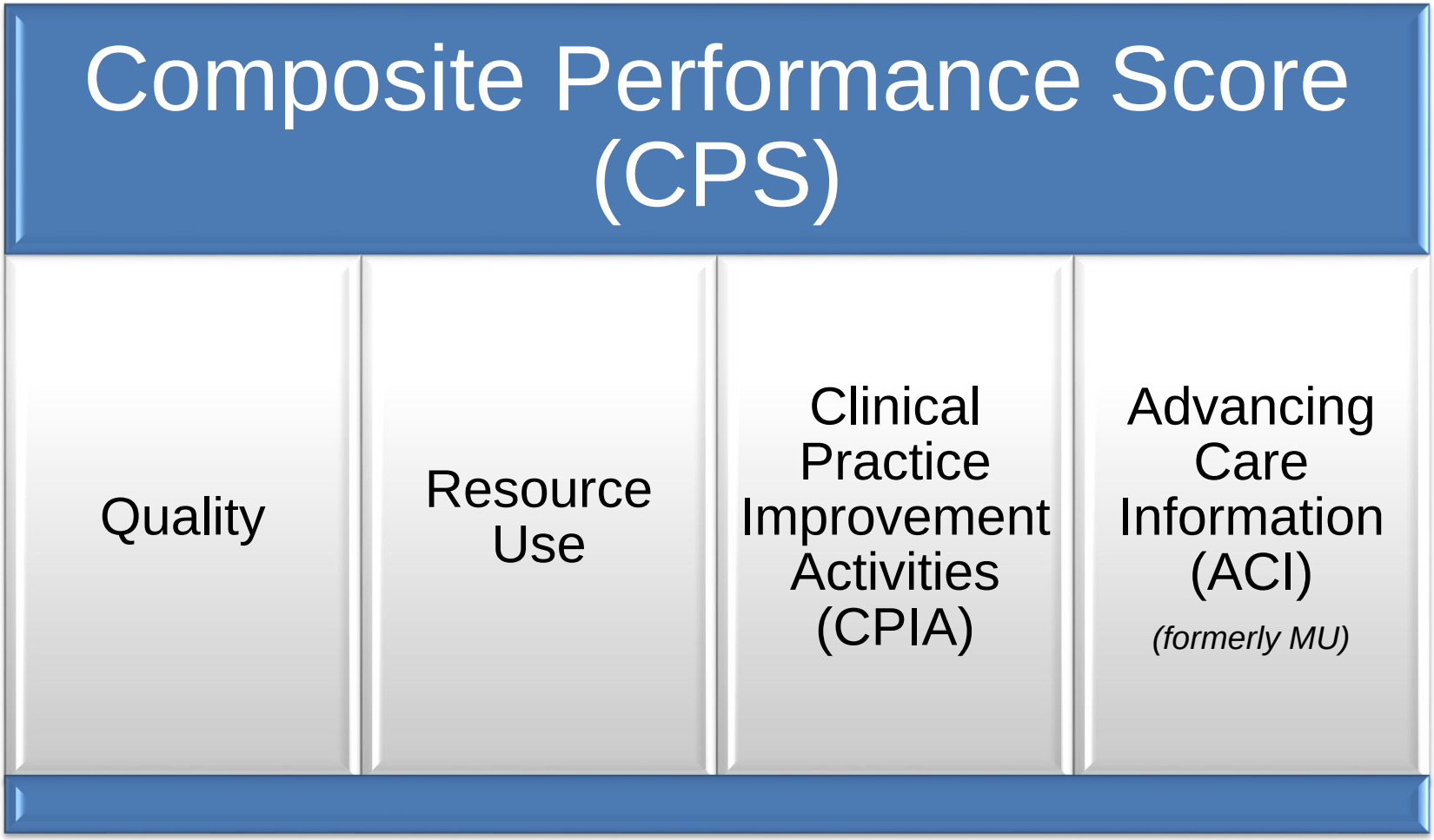
- QCDR
- Registry
- EHR
- GPRO Web Interface
- Claims

Making a Choice

- Must use the same identifier (individual or group) across all 4 performance categories
- Reporting
  - Every measure within the performance category must be reported using the same mechanism
  - Each performance category may be reported using a different mechanism

MIPS Performance Categories

Composite Performance Score: Four Categories



MIPS Performance Categories/Weights

Performance Category	MIPS General*			MIPS APM
	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	
Quality	50%	45%	30%	Varies depending on APM
Resource Use	10%	15%	30%	
CPIA	15%	15%	15%	
ACI	25%	25%	25%	

***For MIPS General weights will be adjusted for certain factors, such as non-patient facing clinicians**

Composite Score Calculation

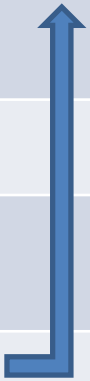
Performance Category	Points Need to Get a Full Score Per Performance Category	Percentage Weight per Performance Category
Quality	80 to 90 points (varying on group size)	50 percent (decreases in later years)
Advancing Care Information (ACI)	100 points	25 percent
Clinical Practice Improvement Activities (CPIA)	60 points	15 percent
Resource Use	Average score of all resource measures that can be attributed	10 percent (increases in later years)

If Secretary determines an Eligible Clinician does not have enough measures, then CMS may change weight distribution. (e.g. non-patient facing clinicians, hospital-based clinicians, significant hardship)

Flexibility in Weighting Categories

Example: In the case where a non-patient facing clinician is unable to report resource use category (e.g. pathologist) due to being unable to meet the case minimum of 20, CMS proposes to reassign the resource use weight to the quality category.

Performance Category	Points Need to Get a Full Score Per Performance Category	Percentage Weight per Performance Category	Percentage Weight Per Performance Category REDISTRIBUTED
Quality **(scoring at least 3 measures)**	80 to 90 points (varying on group size)*	50 percent	60 percent
Advancing Care Information (ACI)	100 points	25 percent	25 percent
Clinical Practice Improvement Activities (CPIA)	60 points	15 percent	15 percent
Resource Use	Average score of all resource measures that can be attributed	10 percent	0 percent



**the total possible points will vary based on the number of measures the clinician qualifies to report*

Quality Measures(Weighted 50%)

- Select from individual measures or a specialty measure set
- Requires reporting 6 measures (instead of 9)
  - 1 of 6 measures must be cross-cutting measure and 1 outcome measure (if not applicable then must be a high priority measure)
- **GPRO web-interface users continue to report 17 measures**
- 2-3 (varying on group size) additional population measures will automatically be calculated by CMS
  - Chronic Condition
  - Acute Condition
  - All-Cause Hospital Readmission **(only for groups of 10+, minimum case of 200)**

Quality Scoring

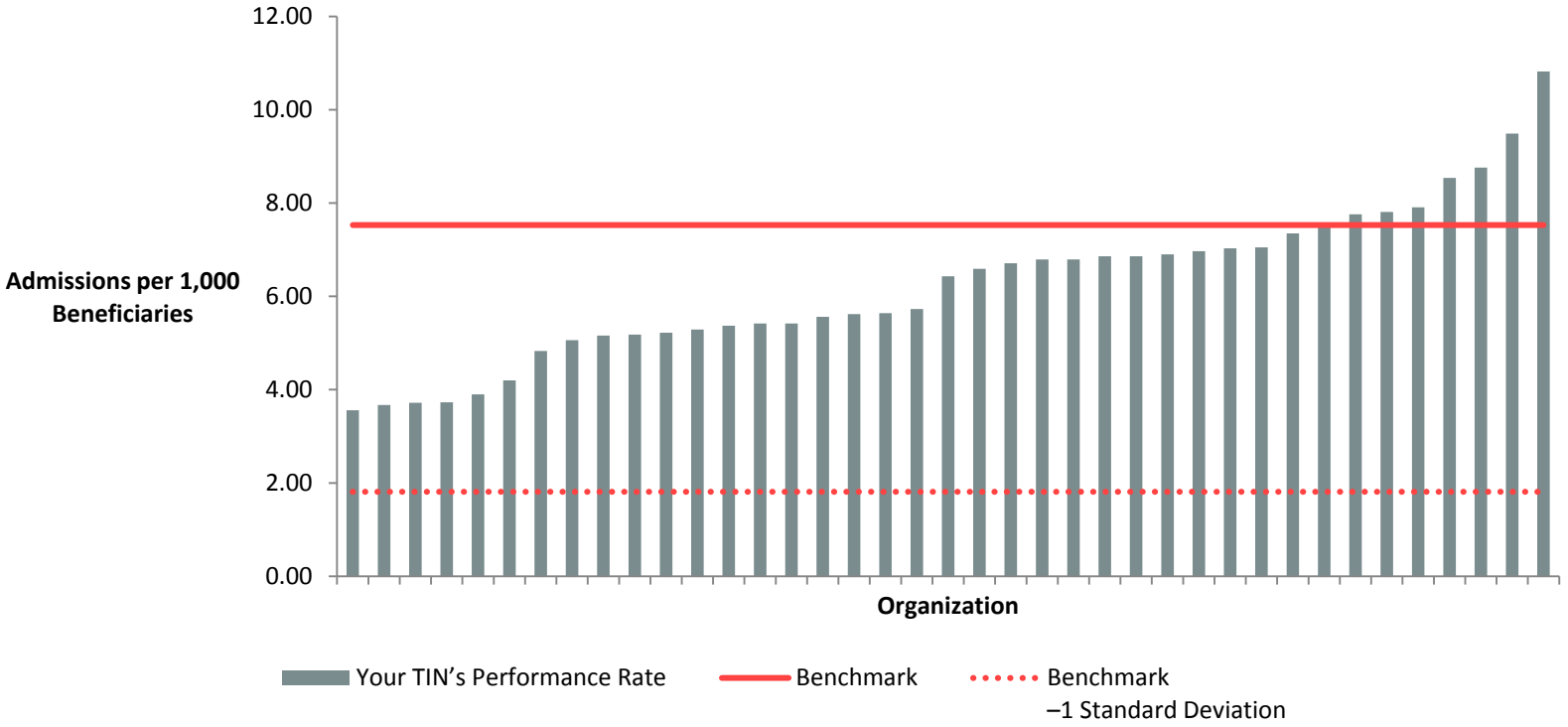
Total points in quality category varies based on numerous factors including: case minimum, number of applicable measures, and group size.

- Each quality measure reported is worth 10 points
  - Bonus points would be available for reporting high priority measures
- **Example**:
  - Group of 10 or more (6 measures+3 population measures): **(6x10)+(3x10)=90 points**
  - Group reporting via GPRO web+ 3 population measures: **(17x10)+(3x10)=200 points**

Resource Use (Weighted 10%)

- Based on current two Value Modifier Program Measures
  - Medicare Spending Per Beneficiary (MSPB)
  - Total Per Capita Cost (includes Medicare Part A and B payments)
- Adds 40+ episode specific measures (for specialty groups)
- No additional reporting required; continues to be calculated on claims
- Excludes services billed under CPT codes 99304-99318 with the POS 31 modifier (SNF visits)

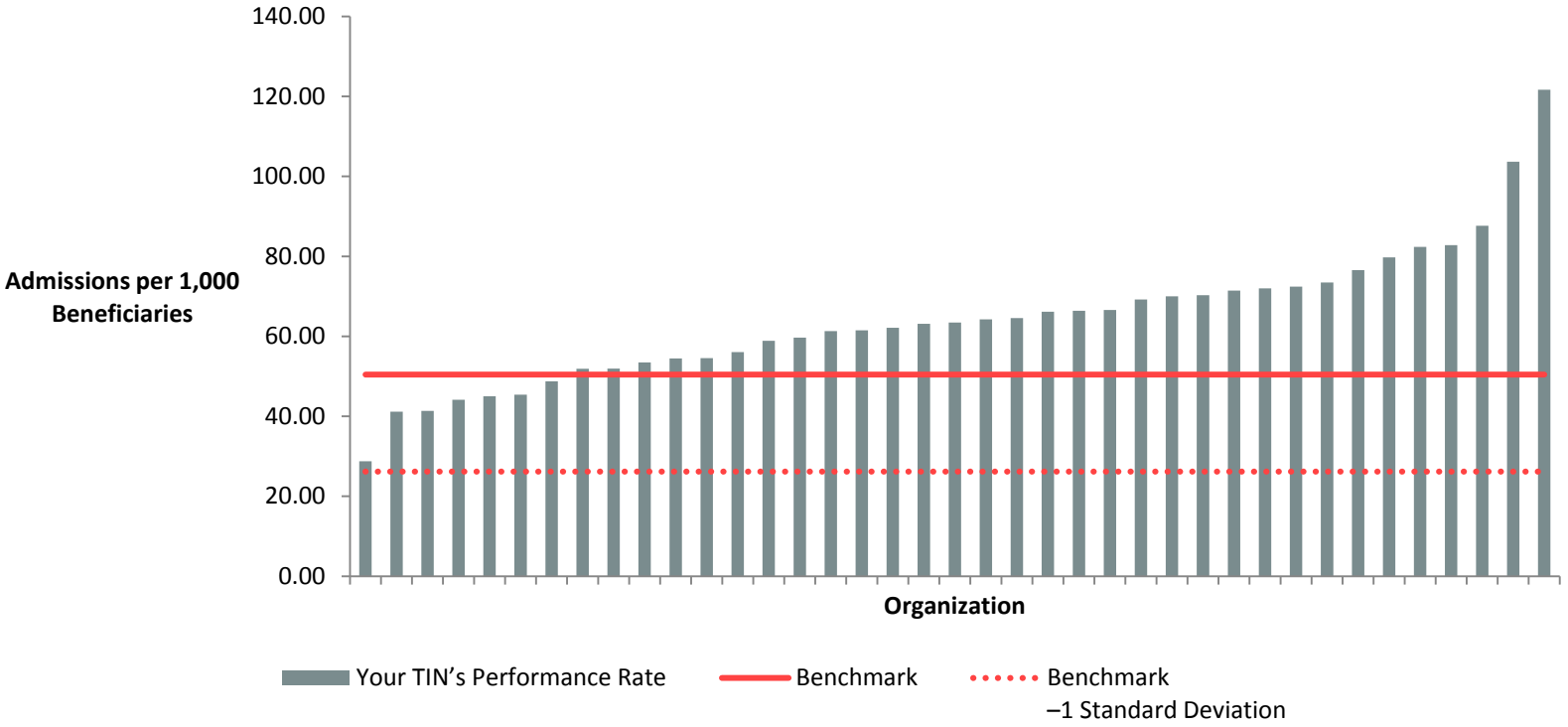
Ambulatory Care Sensitive Conditions: Acute Conditions



80% of academic groups performed better than the national benchmark.

Note: lower rates indicate better performance

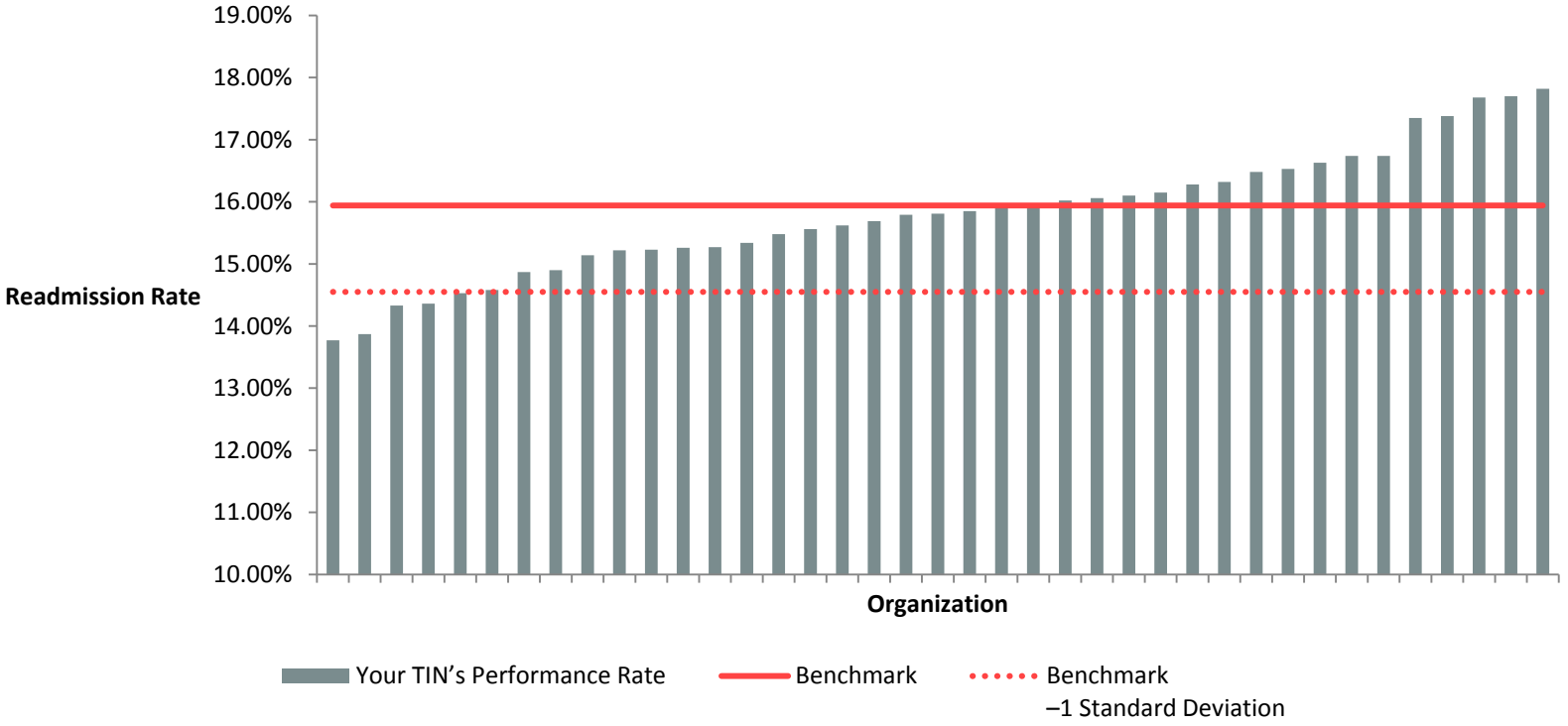
Ambulatory Care Sensitive Conditions: Chronic Conditions



80% of academic groups performed ***worse*** than the national benchmark.

Note: lower rates indicate better performance

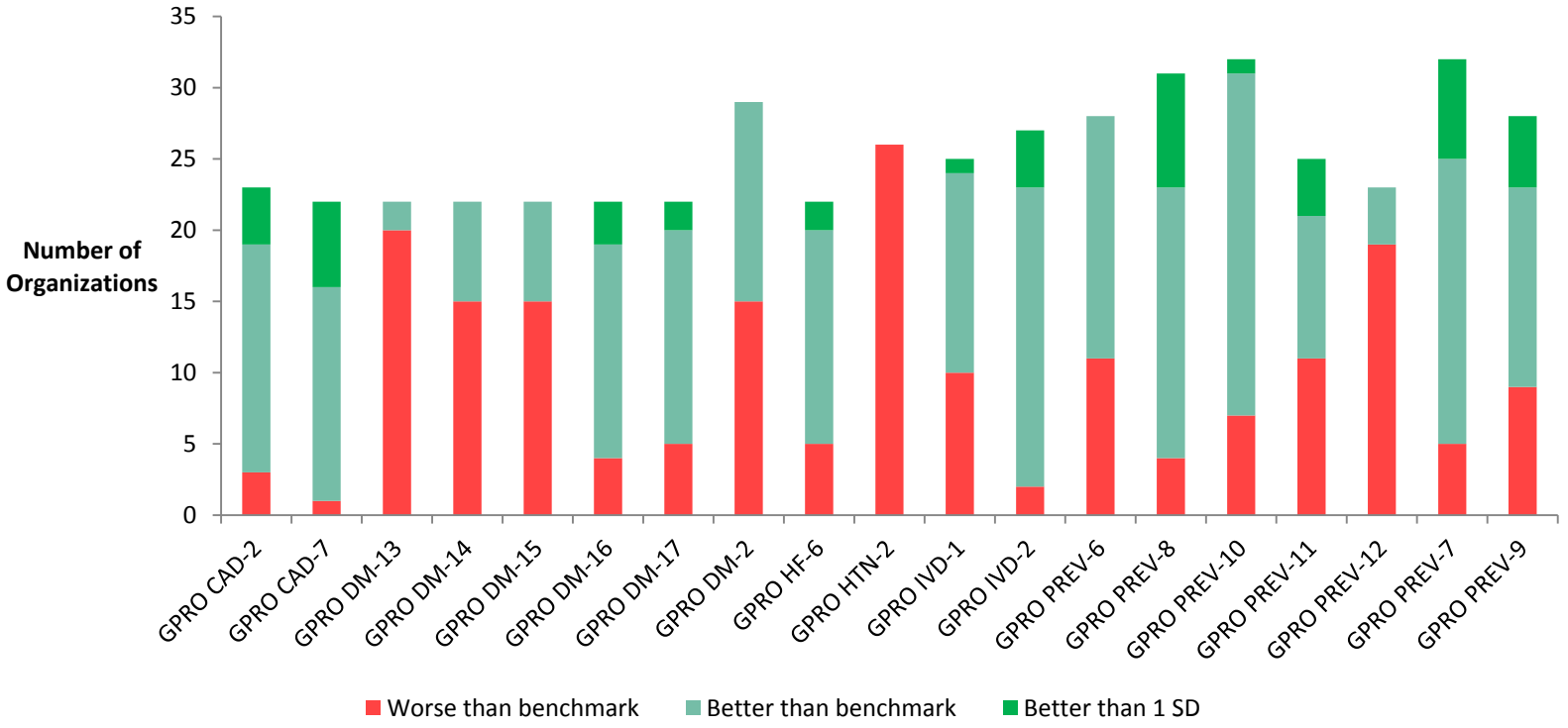
All-Cause Hospital Readmissions



Over half of academic groups performed better than the national benchmark.
1 out of 8 academic groups had performance in the top 15% of all groups nationwide.

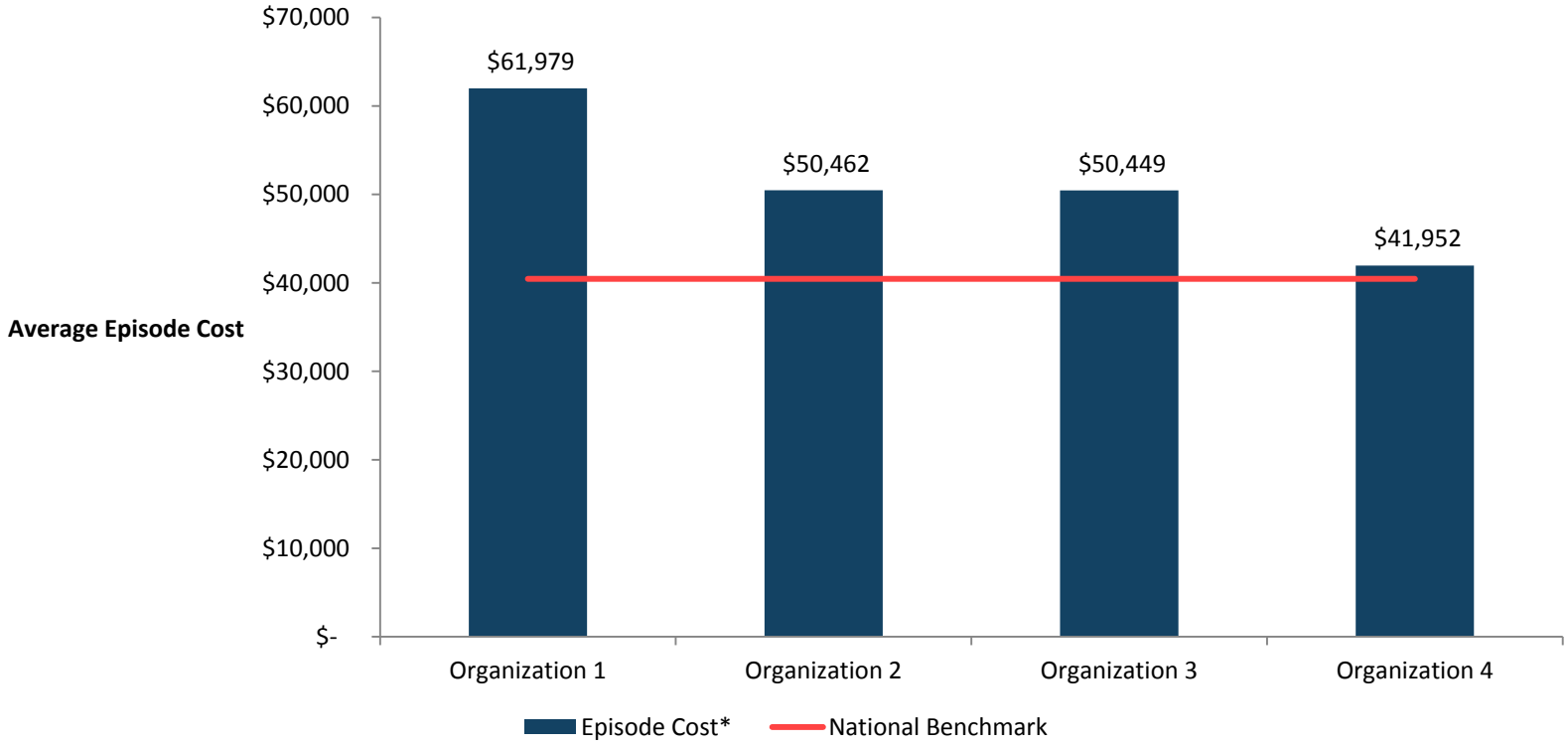
Note: lower rates indicate better performance

PQRS Performance for GPRO Web Interface Users



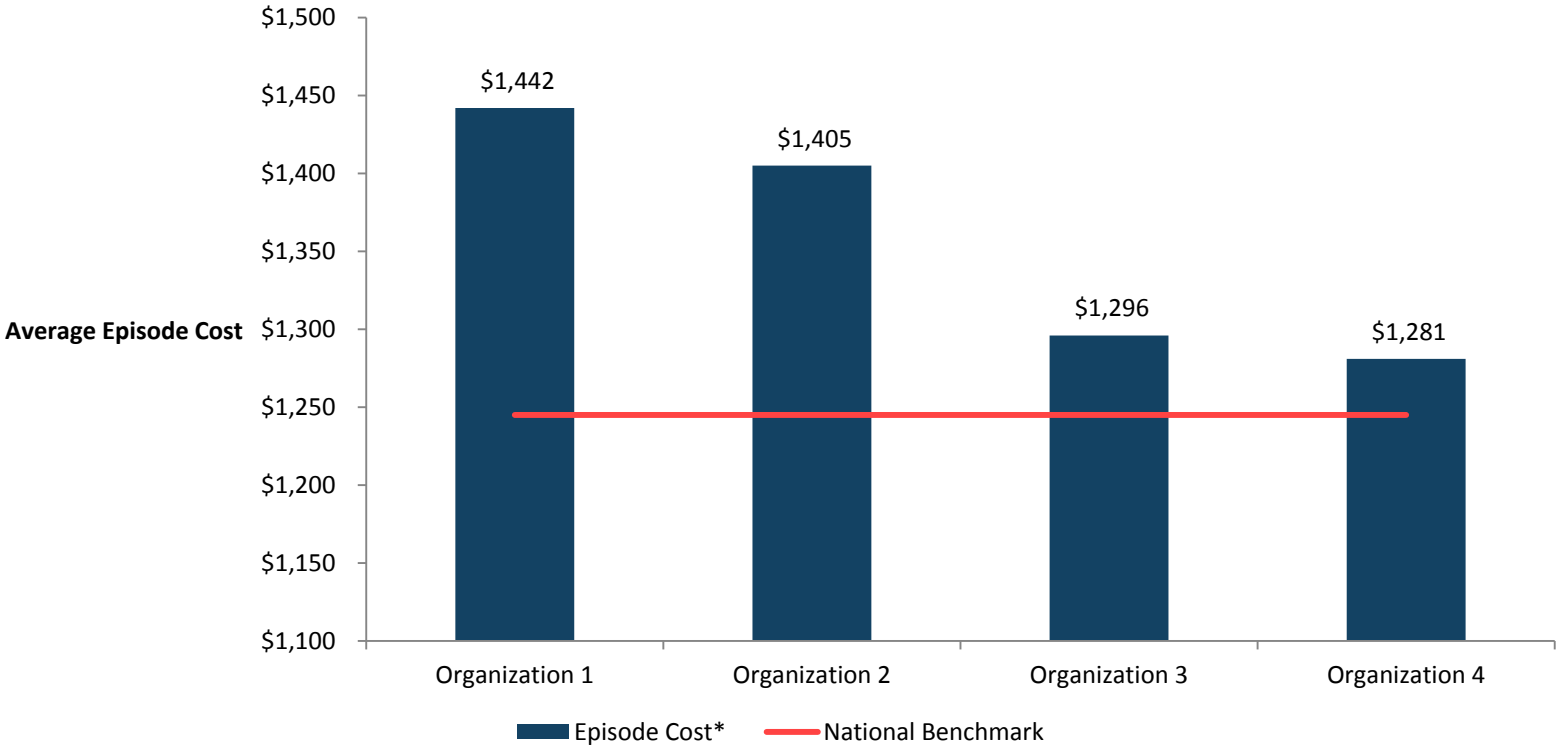
Widespread achievement on many metrics, underperformance on others.

Episode 60: Spinal Fusion (all)



Note: lower cost indicates better performance

Episode 31: Colonoscopy (all)

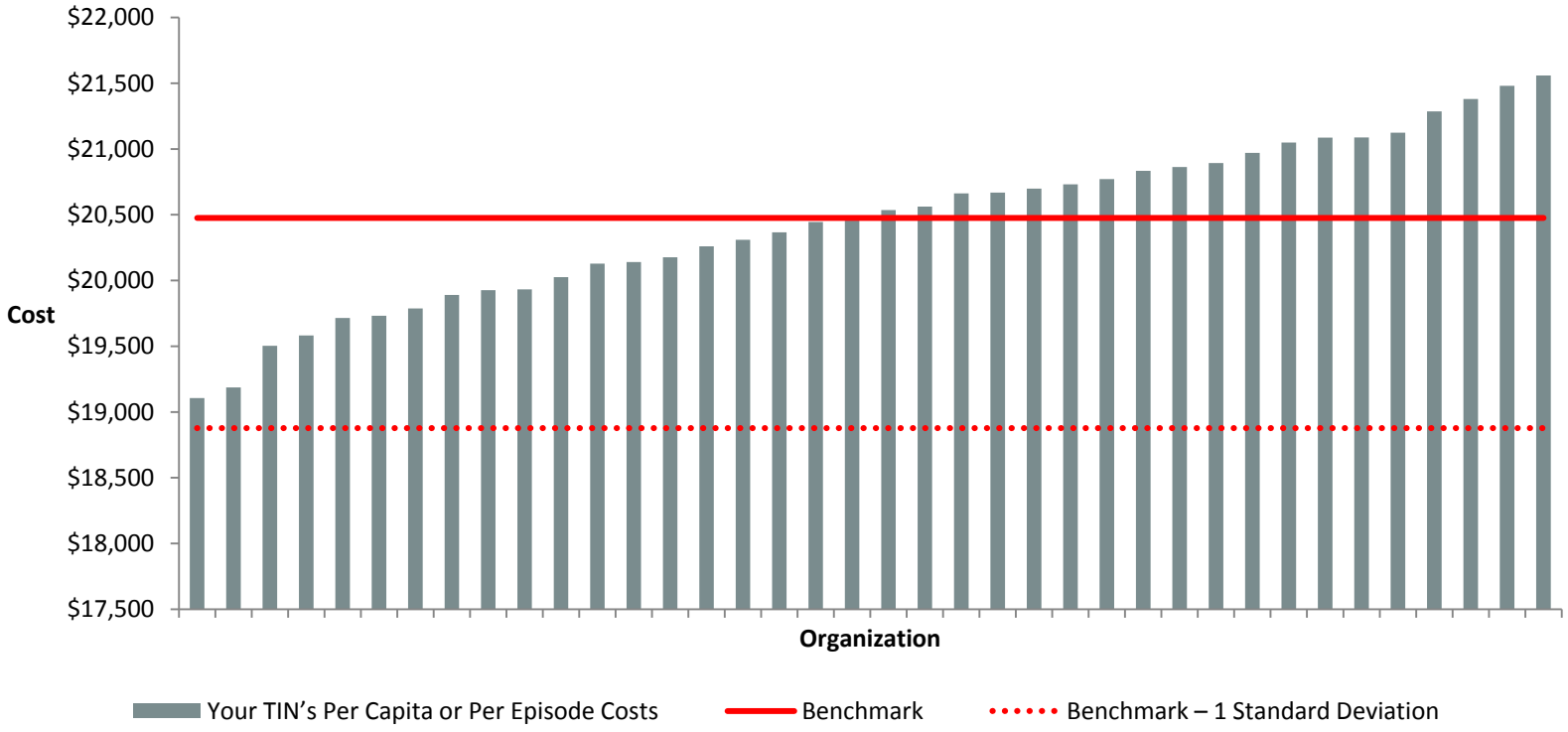


Note: lower cost indicates better performance

Episode 1: Acute Myocardial Infarction (all)

Note: lower cost indicates better performance

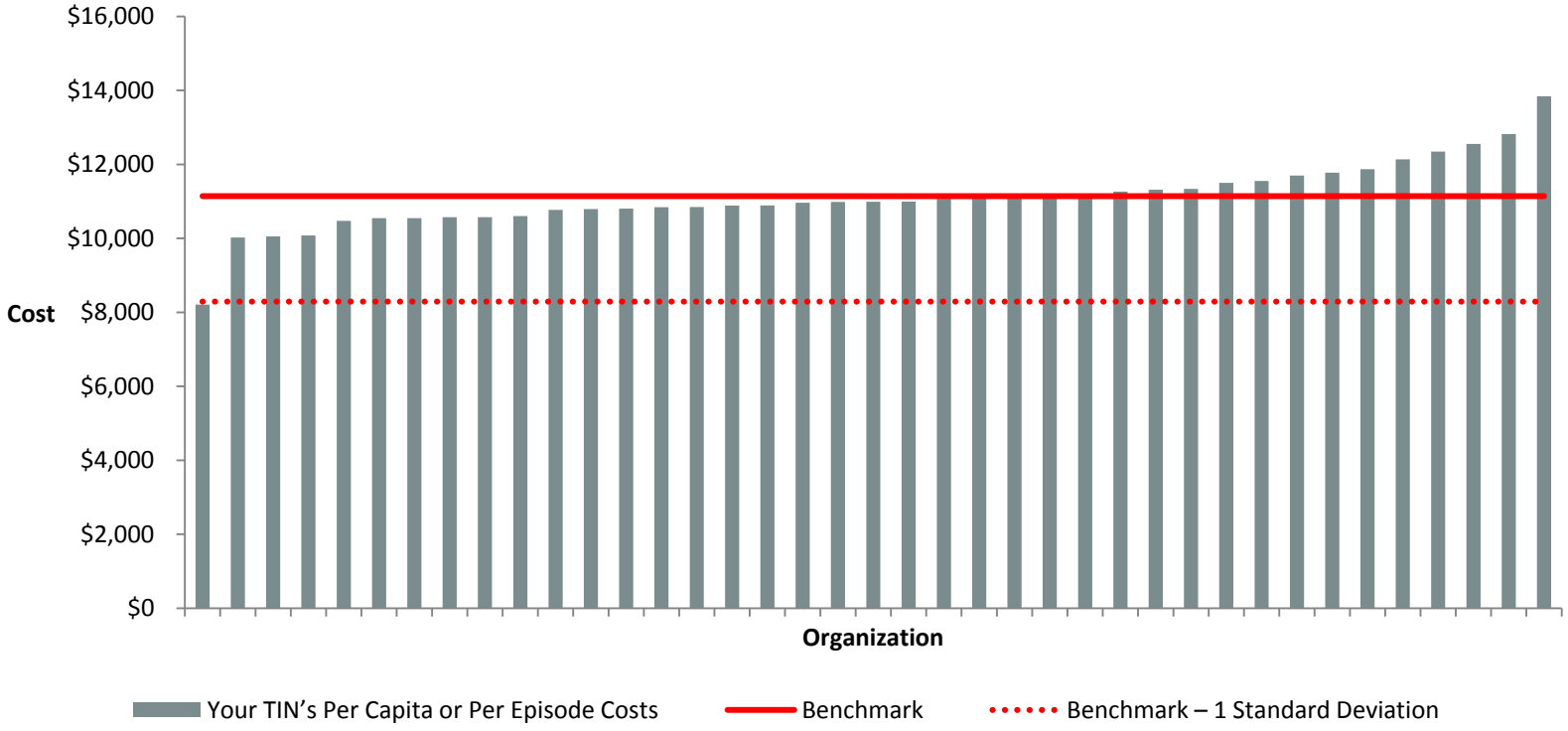
Medicare Spend per Beneficiary (MSPB)



Half of all academic groups performed better than the national average.

Note: lower cost indicates better performance

Total Per Capita or Per Episode Cost: All Beneficiaries



Two thirds of academic groups perform better than the national average. Robust coding and documentation practices ensure proper risk adjustment.

Note: lower cost indicates better performance

Clinical Practice Improvement Activities (weighted 15%) (choose from a list of 94 activities)

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the proposed rule, which are:

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement	Patient Safety & Practice Assessment	Participation in an APM
• Same day appointments for urgent needs • After hours clinician advice	• Monitoring health conditions & providing timely intervention • Participation in a QCDR	• Timely communication of test results • Timely exchange of clinical information with patients AND providers • Use of remote monitoring and Telehealth	• Establishing care for complex patients • Patient self management & training • Employing shared decision making	• Use of clinical or surgical checklists • Practice assessments related to maintain certification	• As defined in prior slide • At a minimum receive ½ CPIA score for APM participation

CMS Proposed Three Additional CPIA Categories

Achieving Health Equity	Integrated Behavioral and Mental Health	Emergency Preparedness and Response
• Achieve high quality for underserved populations	• Shared/integrated behavioral health and primary care records to address substance use disorders or other behavioral health conditions	• Participation in Medical Reserve Corps • Active duty MIPS eligible clinician or group activities

CPIA Scoring

Each activity must be selected and achieved separately for the first year of MIPS and MIPS Eligible Clinicians or groups must perform CPIAs for at least 90 days during the performance period.

Total Possible Points: 60

- As a Medical Home participant, you will receive full credit
- An ACO receives ½ credit (30 points)

CPIAs fall in two categories: high-weighted (20 points) and medium-weighted (10 points)

- Eligible Clinicians can select a combination of high-weighted and medium-weighted activities to receive full credit
- **Example**: 2 medium activities and 2 high-weighted activities: (2x10)+(2x20)=60 points

**Non-patient facing MIPS eligible clinicians and groups can report on a minimum of 1 activity to achieve partial credit or 2 activities to achieve full credit.*

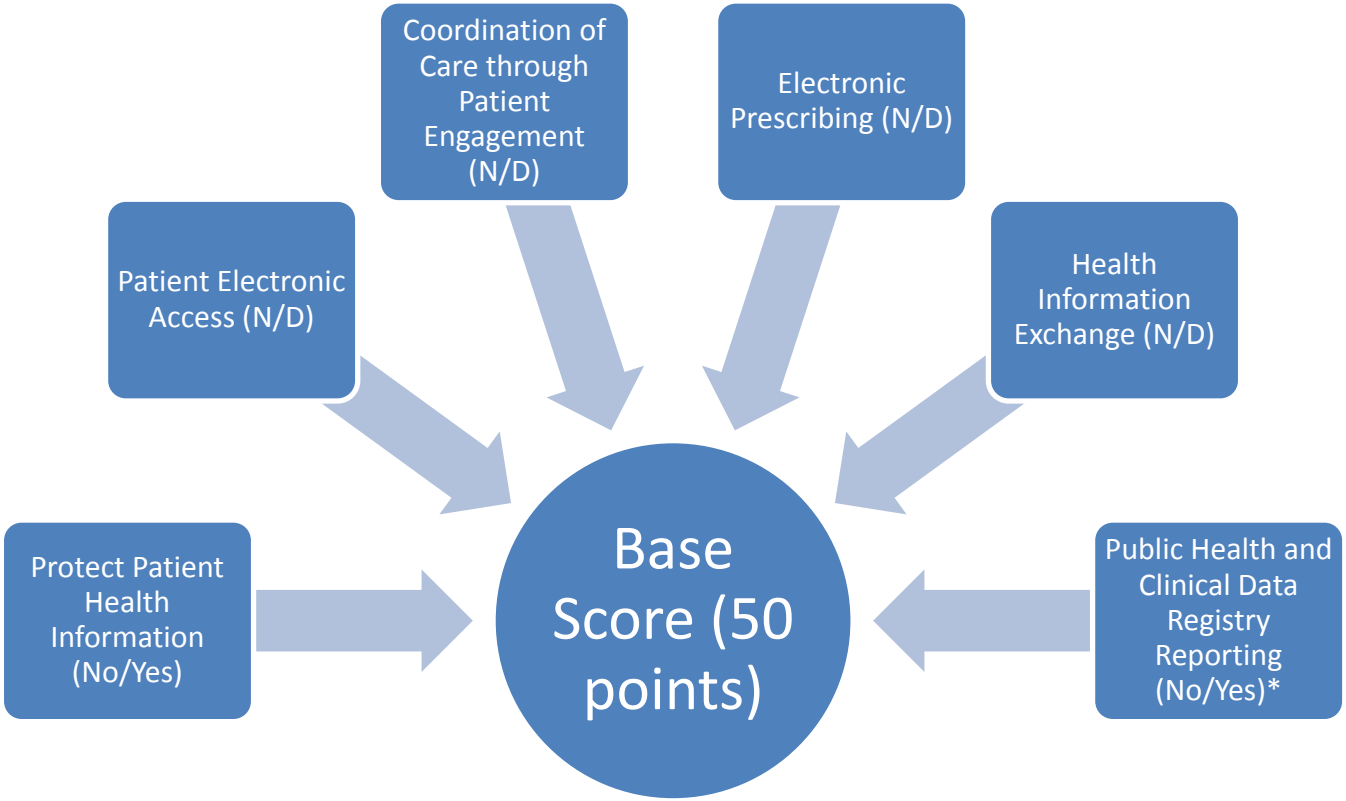
Refer to Table 23, 81 Fed. Reg. p. 28262-28265 to get a list of the 11 high-weighted activities. Appendix H lists all activities.

Advancing Care Information (weighted 25%) (Replaces Meaningful Use Program)

Key Changes from Current EHR Program	Can report as Individuals and Groups
	Scoring based on two categories: Base and Performance Scores
	Failure to meet requirement to protect patient health information in EHR = 0 score for performance category
	More flexibility in choosing measures to report for Performance Score
	Removed Reporting Requirement for Clinical Provider Order Entry and Clinical Decision Support Objectives
	Optional reporting for: NPs, PAs, CNS, CRNAs

ACI: Overview of Base Score

**An Eligible Clinician must complete submission on the immunization registry reporting measure of this objective and the measure, if applicable.*



All or nothing approach means **must**:

- provide the numerator/denominator or yes/no for each objective and measure
- failure to meet requirement to protect patient health information in EHR will result in 0 base score and 0 score in performance category

ACI: Overview of Performance Score

Performance Score (up to 80 points)

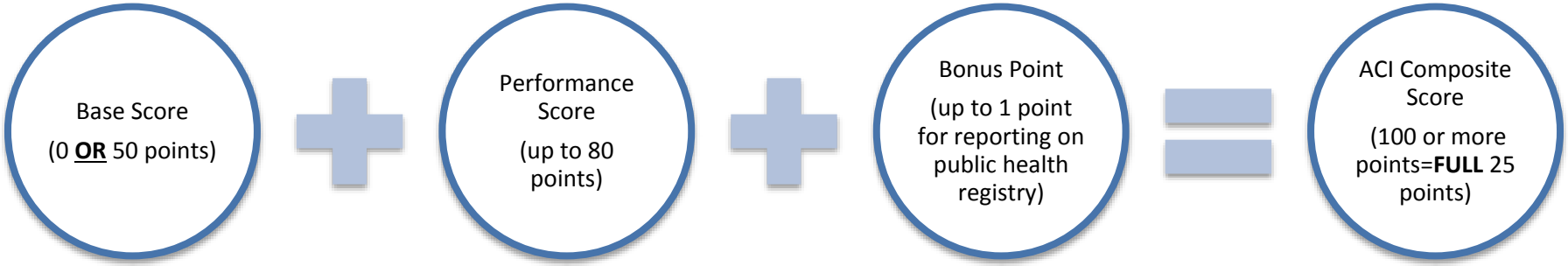
Patient Electronic Access	Coordination of Care through Patient Engagement	Health Information Exchange
• Patient Access • Patient Specific Education	• VDT • Secure Messaging • Patient-Generated Health Data	• Patient Care Record Exchange • Request/Accept Patient Care Record • Clinical Information Reconciliation

Clinicians <u>can</u>:

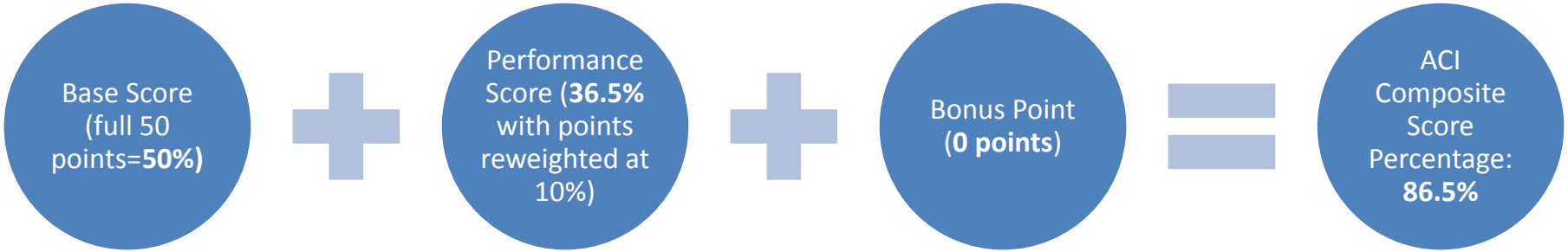
- Select measures that best fit their practices from the 8 associated measures from the 3 objectives
- For each measure reported under the Performance Score a clinician can receive up to 10 percent of their Performance Score based on their performance rate for the given measure.

ACI: Scoring

Clinicians can receive up to 131 points. If they earn 100 points or more then they receive the full 25 points.



Example Calculation:



86.5% x 25=21.625 points for ACI Composite Score

Limited Exceptions

If Secretary determines an Eligible Clinician does not have enough measures, then CMS may change weight distribution. (e.g. non-patient facing clinicians, hospital-based clinicians, significant hardship)

Hospital-based Physicians

- **Definition:** a MIPS eligible clinician who furnishes 90 percent or more of his or her covered professional services in sites of services identified by the codes used in the HIPAA standard transaction as an inpatient or ER setting in the year
- **ACI category**: proposes to assign a weight of 0 to the ACI category
- **Resource Use category:** may have similar exceptions as non-patient facing physicians (*seeking feedback)*

Non-patient Facing Physicians

- **CPIA category:** Non-patient facing MIPS eligible clinicians and groups can report on a minimum of 1 activity to achieve partial credit or 2 activities to achieve full credit.
- **Resource Use category:** May not be attributed any resource use measures that are generally attributed to clinicians who have patient facing encounters with patients

MIPS/APM

Eligible Clinicians Participating in APMs

MIPS/APM

- Defined by APM Identifier
- Participate in an APM that isn't an Advanced APM or doesn't meet Advanced APM full or partial threshold
- Reporting mechanism varies by APM model

Each Eligible Clinician who is a participant in an APM Entity would be identified by unique APM participant identifier—combination of 4 identifiers

- APM Identifier-established by CMS (this is the model)
- APM Entity Identifier-established by CMS– this is entity (e.g. ACO)
- Tax Identification Numbers-9 numeric characters
- Eligible Clinicians NPI-10 numeric characters

MIPS APMs and Scoring

Eligible Clinicians considered part of APM Entity	• Must be on APM participation list on December 31 of MIPS performance year • If not on list, must report under standard MIPS methods (group or individual)
Criteria for MIPS APM	• APM Entities participate in APM under agreement with CMS • APM Entities include eligible clinicians on participation list • APM bases payment incentives on performance on cost/utilization and quality measures
Examples	• Shared savings program (all tracks) • Next Generation ACO • CPC Plus • Oncology Care

MIPS APM Scoring for Eligible Clinicians in Shared Savings Program

MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	Submit quality measures to CMS web Interface for participating eligible clinicians	MIPS quality performance category requirements and benchmarks will be used to determine category at ACO level	50%
Resource Use	MIPS eligible clinicians not assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians submit according to the MIPS requirements and have performance assessed as a group through billing TINs associated with ACO	All ACO participants group's TINs will receive one half of the possible points at a minimum. If the TIN is a PCMH, it will receive the highest possible score. All scores for MIPS eligible clinicians (under the ACO TIN) in APM entity group will be aggregated, weighted and averaged to one score	20%
Advancing Care Information	All MIPS eligible clinicians submit according to MIPS requires and performance assessed as a group through their billing TINs associated with the ACO	All of ACO participant group billing scores aggregated, as a weighted to score to yield one group score	30%

MIPS APM Scoring for Eligible Clinicians in Next Generation

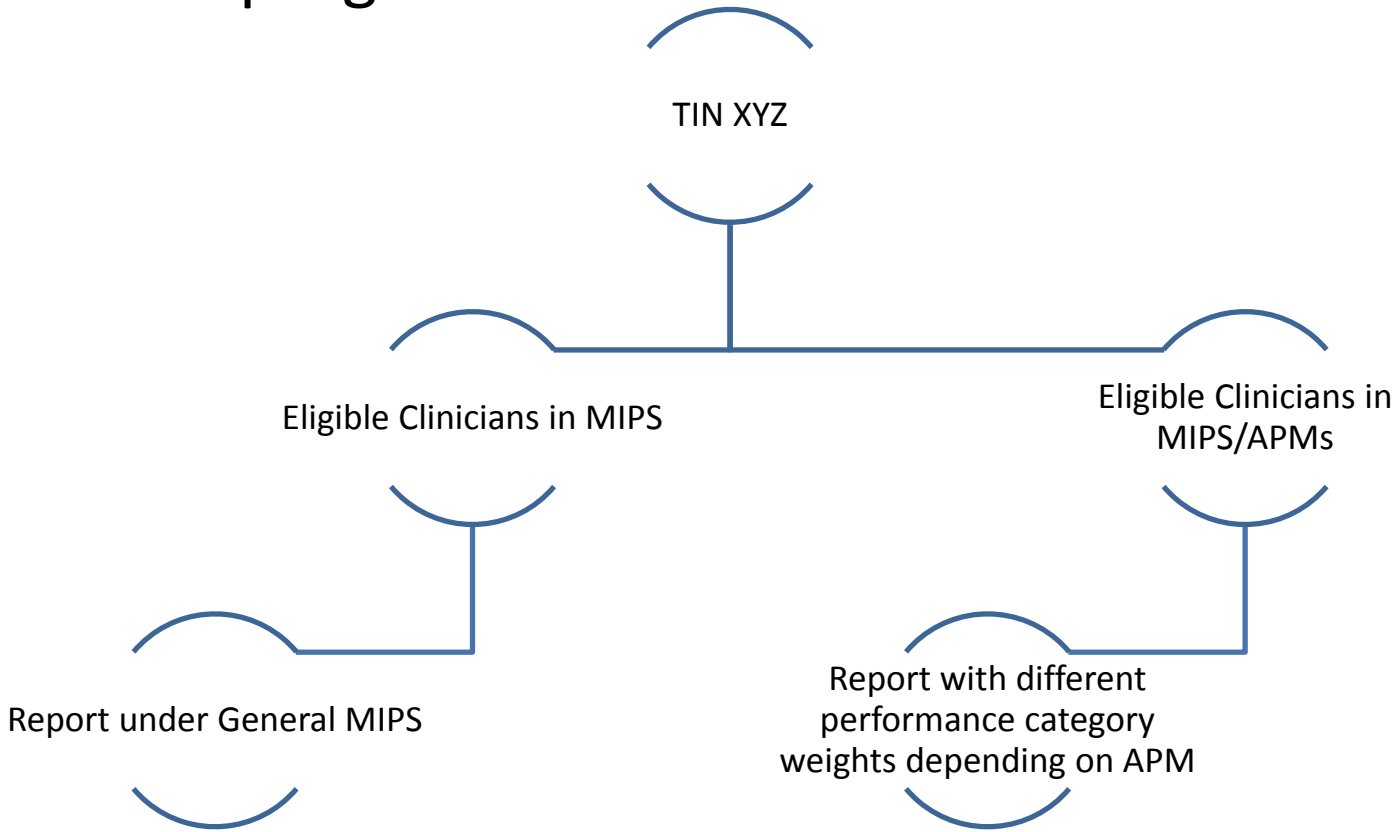
MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	Submit quality measures to CMS web Interface for participating eligible clinicians	MIPS quality performance category requirements and benchmarks will be used to develop ACO MIPS quality score.	50%
Resource Use	MIPS eligible clinicians not assessed	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM entity group submit individual level data.	All ACO eligible clinicians will receive one half of the possible points at a minimum. If eligible clinician is in a PCMH, will receive the highest possible score. All MIPS eligible clinician scores will be aggregated and averaged to one ACO score.	20%
Advancing Care Information	All MIPS eligible clinician's in APM Entity group submit individual level data.	All of MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	30%

MIPS APM Scoring Other (not MSSP or Next Gen)

MIPS Performance Category	Data Submission Requirement	Performance Score	Weight
Quality	The APM Entity group would not be assessed on quality in first performance period. APM submits quality measures as required by APM.	N/A	0%
Resource Use	MIPS eligible clinician	Not applicable	0%
CPIA	All MIPS eligible clinicians in the APM entity group submit individual level data.	All ACO eligible clinicians will receive one half of the possible points at a minimum. If eligible clinician is in a PCMH, will receive the highest possible score. All MIPS eligible clinician scores will be aggregated and averaged to one ACO score.	25%
Advancing Care Information	All MIPS eligible clinician's in APM Entity group submit individual level data.	All of MIPS eligible clinician scores will be aggregated and averaged to yield one ACO score. An ACO eligible clinician that does not report this performance category would contribute a score of zero.	75%

Case Example

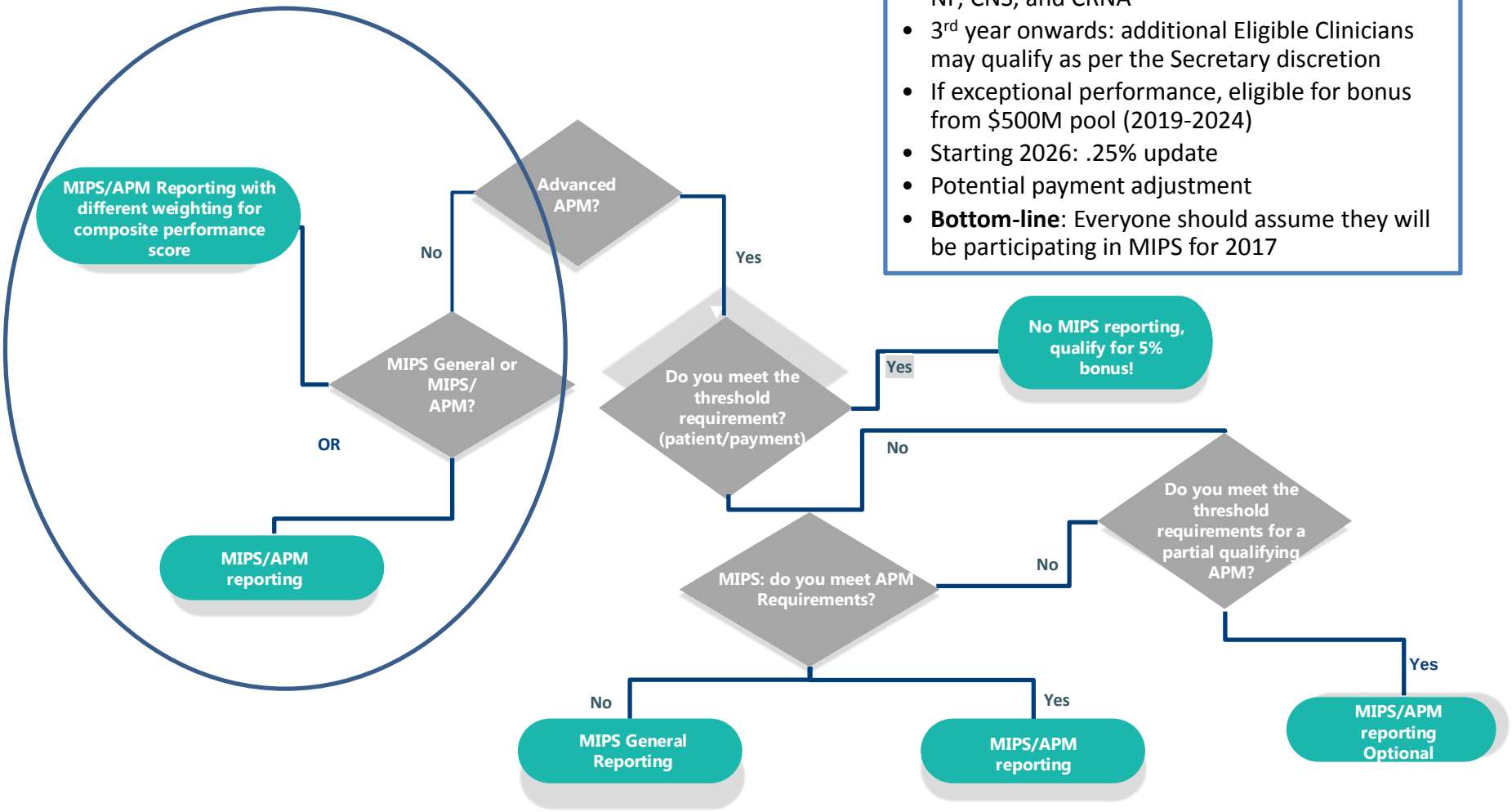
REMEMBER—it is possible that parts of your TIN may be in different programs!



MIPS: General or APM?

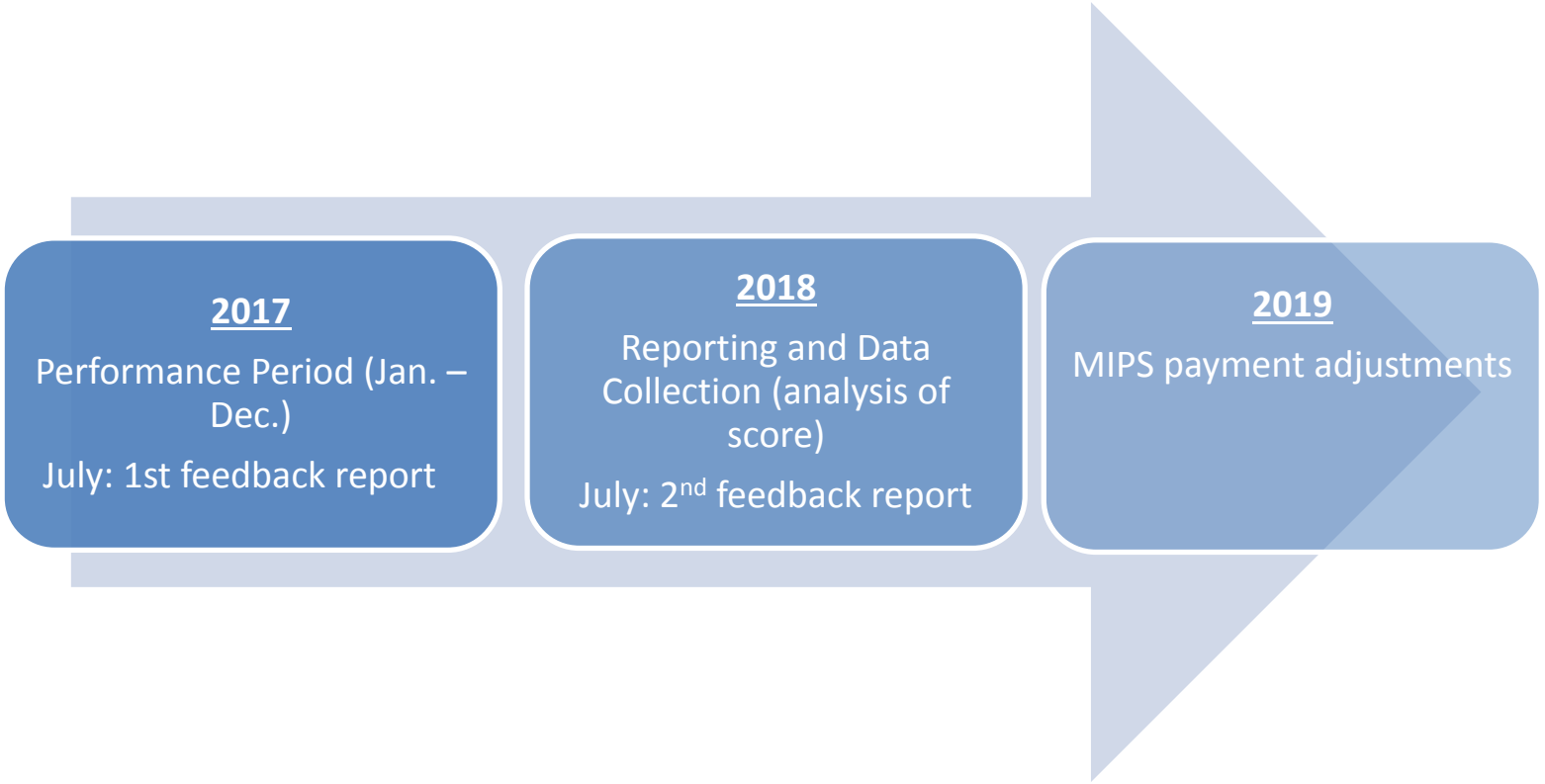
Summary

- Eligible Clinicians for first 2 years: physician, PA, NP, CNS, and CRNA
- 3rd year onwards: additional Eligible Clinicians may qualify as per the Secretary discretion
- If exceptional performance, eligible for bonus from $500M pool (2019-2024)
- Starting 2026: .25% update
- Potential payment adjustment
- **Bottom-line**: Everyone should assume they will be participating in MIPS for 2017



Payment Adjustments Under MIPS

MIPS Timeline



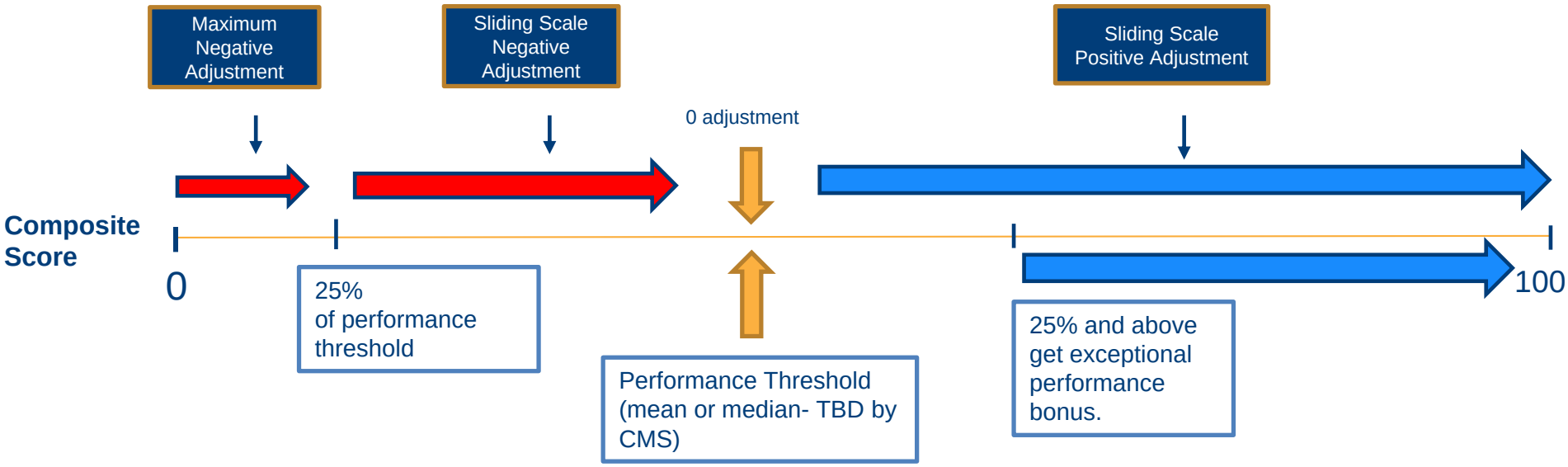
MIPS Payment Adjustment

Based on the MIPS composite performance score, providers receive positive, negative, or neutral payment adjustments

Year	Payment Adjustments
2019	±4%
2020	±5%
2021	±7%
2022 and beyond	±9%

Exceptional performers may be eligible for additional payments

MIPS Payment Adjustment



Performance Threshold

- Will use 2014-2015 Part B charges, PQRS data submissions, QRUR and sQRUR feedback data, and Medicare and Medicaid MU data
- Approximately half of eligible clinicians will be above threshold and half below
- Budget neutrality required

Additional Payments for Exceptional Performers

Eligible Clinicians with scores above performance threshold, can have adjustment increased or decreased by a scaling factor of up to 3, BUT must maintain budget neutrality

- EX: for 2019 could be 3 x 4% = 12%

2019-2024 additional incentive payment: up to $500m pool each year for exceptional performance

- Maximum adjustment cannot be more than 10% of Eligible Clinicians' Medicare payments
- Exceptional performance: 25th percentile of CPS for MIPS eligible clinicians at or above the performance threshold

Other Topics Related to MIPS

MIPS Public Reporting

Information about the performance of MIPS Eligible Clinicians must be made available on Physician Compare:

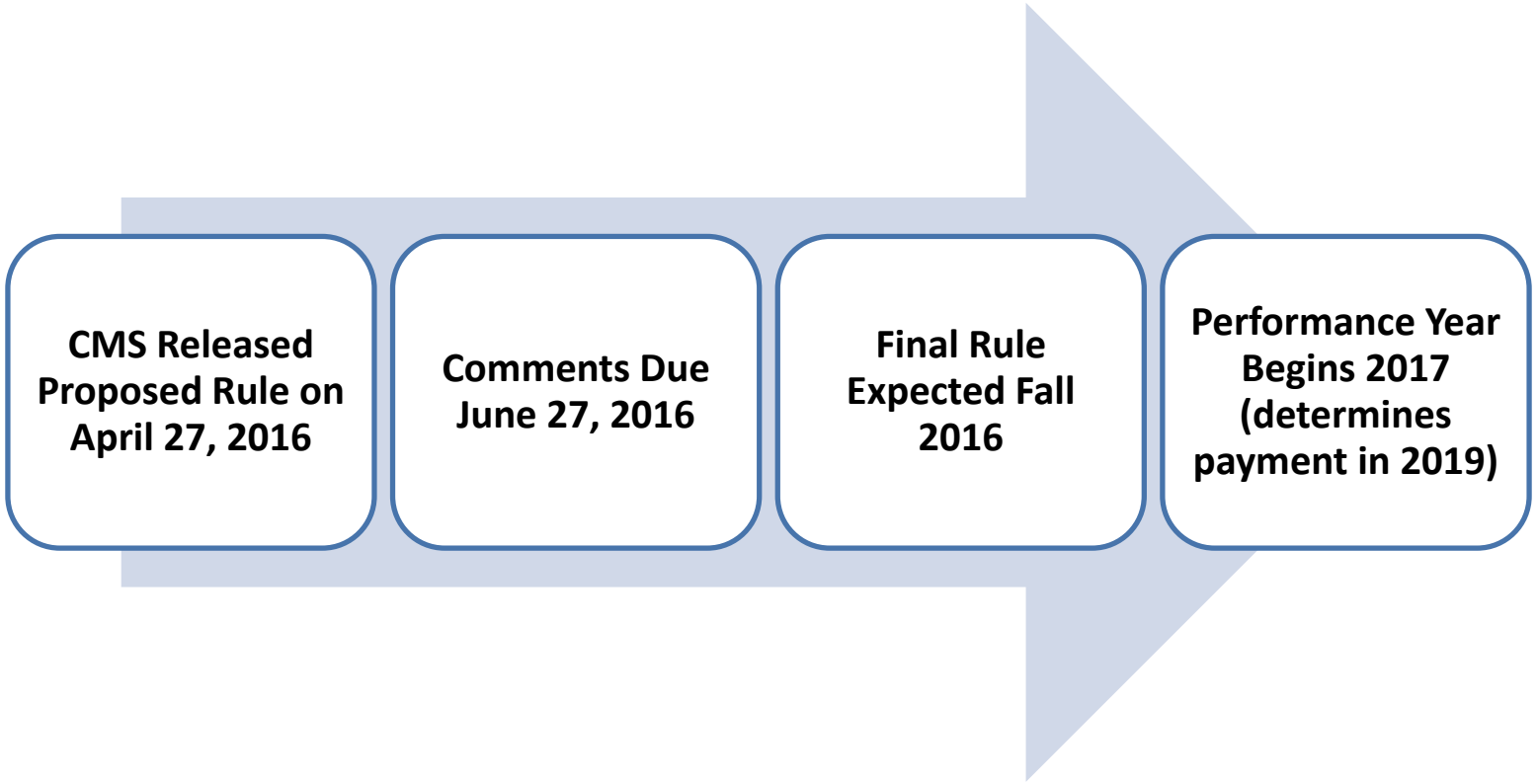
- Composite score for each Eligible Clinician and performance in each category
- Names of Eligible Clinicians in APMs
- May include performance regarding each measure or activity in resource use

MACRA Transition Timeline

<table>
<tr><th></th><th>Jul-Dec 2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th><th>2021</th><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026 and beyond</th></tr>
<tr><td>Annual Updates</td><td colspan="5">+0.5%</td><td colspan="6">+0.0%</td><td>2 Options:
Qualifying APM: +0.75%
Other: +0.25%</td></tr>
<tr><td>PQRS Penalty</td><td colspan="4">2%</td><td colspan="8" rowspan="3">Penalties transition to MIPS; $500M pool for additional incentives for exceptional performance</td></tr>
<tr><td>Medicare EHR Penalties</td><td>1% or 2%</td><td>2%</td><td>3%</td><td>3% or 4%</td></tr>
<tr><td>VM Max Penalty*</td><td>Up to 1%</td><td>Up to 2%</td><td>Up to 4%</td><td>TBD</td></tr>
<tr><td colspan="5">Merit-Based Incentive Payment System (MIPS)*
(Only max reduction listed; incentives available, see notes)</td><td>4% at risk</td><td>5% at risk</td><td>7% at risk</td><td colspan="3">9% at risk</td><td>+0.25% update + (9%) at risk</td></tr>
<tr><td colspan="11">Exclusions from MIPS</td><td></td></tr>
<tr><td colspan="6">Qualifying APM Participant (QP)</td><td colspan="4">Bonus: 5% lump sum payment
(based on services in preceding year); No MIPS risk</td><td>No Bonus; No MIPS risk</td><td>+0.75% update; No MIPS risk</td></tr>
<tr><td colspan="6">Other MIPS Exclusions
(Low volume; Partial Qualifying APM w/ no MIPS reporting)</td><td colspan="5">No Bonus, No MIPS risk</td><td>+0.25% update; No MIPS risk</td></tr>
</table>

* VM and MIPS have possible upward or downward adjustments. Due to budget neutrality, incentives scale based on available funds. Maximum reduction for MIPS listed in statute.

Regulatory Timeline



References to Additional Tables

- The proposed rule's link : https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf
- Proposed Clinical Condition and Treatment Episode-Based Measures: *Table 4, 81 Fed Reg. p. 28202-28206*
- High Weight CPIAs: *Table 23, 81 Fed. Reg. p. 28262-28265*
- List of Advanced APMs: *Table 32, 81 Fed. Reg. p. 28312-28313*
- 2017 Proposed MIPS specialty Measure sets: Table E
- *Proposed Individual Quality Measures Available for MIPS reporting in 2017: Table A*

Questions?

Part 2 Webinar **TOMORROW!**

FPSC FY 2017 MACRA Provisions Focusing on APMs
Date and Time: Thursday, June 2, 2016 12:00pm – 1:00pm EST
Registration Link /Event address for attendees:
https://uhcevents.webex.com/uhcevents/onstage/g.php?MTID=e714728598a779b0cc7db90e51c78e7e8

Duration: 1 hour

Email: teachingphysicians@aamc.org for any additional questions.