2018 MACRA Final Rule Detailed Analysis

Your Guide to New Flexibilities and Challenges in the Quality Payment Program

Ye Hoffman, MS, CPHIMS
Consultant
December 12, 2017
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2018 MACRA Final Rule Detailed Analysis

Your Guide to New Flexibilities and Challenges in the Quality Payment Program

Ye Hoffman, MS, CPHIMS
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December 12, 2017
Key Takeaways from the 2018 QPP Final Rule

1. Advanced Alternative Payment Models (Advanced APM)

2. Merit-Based Incentive Payment System (MIPS)

3. Action Items
Advisory Board MACRA\(^1\) Webconferences

Overview and Detailed Analysis for All Members

**MACRA: How the 2018 Quality Payment Program Final Rule Impacts Providers**

**Available On Demand**

- The most important changes in the 2018 QPP\(^2\) final rule
- Next steps for provider organizations in response to the final rule

**2018 MACRA Final Rule Detailed Analysis: Your Guide to New Flexibilities and Challenges in the Quality Payment Program**

**Today**

- The details of the 2018 QPP final rule
- Action items on reporting and program management
- How to prepare for success in future years

For More Advisory Board Resources on MACRA

[https://www.advisory.com/macra](https://www.advisory.com/macra)

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1) MACRA = Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015; 2) QPP = Quality Payment Program.
## Reviewing the Year 2 Timeline

### MACRA Implementation Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 16, 2015</td>
<td>MACRA signed into law</td>
</tr>
<tr>
<td>November 2, 2017</td>
<td>Final 2018 QPP rule released</td>
</tr>
<tr>
<td>April – June, 2018</td>
<td>Payers submit eligibility information for the all-payer combination model</td>
</tr>
<tr>
<td>January 1, 2019</td>
<td>Commencement of Medicare payment adjustment</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>First performance year began</td>
</tr>
<tr>
<td>January 1, 2018</td>
<td>Second performance year begins</td>
</tr>
<tr>
<td>July 1, 2018</td>
<td>CMS releases MIPS cost data to eligible clinicians</td>
</tr>
</tbody>
</table>

### Many Providers Remain Unaware and Unprepared

- **80%**: Provider organizations that have not developed their MACRA strategy yet
- **47%**: Respondents do not know which payment track they are subject to

### What’s In, What’s Out: 2018 QPP Final Rule

<table>
<thead>
<tr>
<th>Advanced Alternative Payment Models (Advanced APM)</th>
<th>Merit-Based Incentive Payment System (MIPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ More participants, more Advanced APMs qualify in 2018</td>
<td>✔ Exclusions expanded, results in more providers excluded from MIPS</td>
</tr>
<tr>
<td>✔ No maximum provider limit for Round 1 CPC+ participants</td>
<td>✔ Framework maintained, many category requirements remain as is</td>
</tr>
<tr>
<td>✔ All-Payer Combination APM option details, applications open in 2018, program starts in 2019</td>
<td>✔ Quality and Cost category changes, key determinant of highest performing ECs</td>
</tr>
<tr>
<td>✗ Different performance periods for Medicare and all-payer APMs</td>
<td>✗ Facility-based scoring option not finalized for 2018</td>
</tr>
<tr>
<td>✗ Limitation that all-payer eligibility can be determined only at the individual level</td>
<td>✗ “Mix-and-match” reporting within a single category not finalized for 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Future New Policies</th>
<th>? Part D drug costs may be included in Cost category</th>
</tr>
</thead>
<tbody>
<tr>
<td>? Medicare Advantage may help providers qualify for the APM track before 2019</td>
<td>? Episode-based cost measures may be introduced</td>
</tr>
<tr>
<td>? New physician-focused payment models may be proposed in the future</td>
<td>?</td>
</tr>
</tbody>
</table>

Source: CMS. “Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year,” November 16, 2017, [https://federalregister.gov/d/2017-24067](https://federalregister.gov/d/2017-24067); Advisory Board research and analysis.

1) CPC+ = Comprehensive Primary Care Plus; 2) ECs = Eligible clinicians.

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Automatic MIPS Exemption Due to Natural Disasters

Affected Providers Need Not Participate in 2017 and Avoid 2019 Penalty

Hardship Issues

Option 1: Take an Automatic Hardship
- No need to submit a hardship application
- No MIPS data submission, and receive three points

Option 2: Participate in MIPS
- Submit data for at least two MIPS performance categories
- All MIPS scoring and payment adjustment policies apply

Financial Implications

Only Penalty Avoidance

Penalty Avoidance and Potential Incentive Payments

Identifying MIPS ECs in Affected Areas
- Based on the practice location address listed in PECOS
- Affected areas designated on the Federal Emergency Management Agency (FEMA) website

1) PECOS = The Provider Enrollment, Chain and Ownership System.
Who Is In and Who Is Out of MACRA?

Exclusions Expanded in 2018 QPP Year 2

<table>
<thead>
<tr>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Medicare Part B payments (i.e., clinician professional payments)</td>
<td>✗ Medicare Part A (i.e., inpatient, outpatient technical hospital payments)</td>
</tr>
<tr>
<td>✓ Physicians, PAs,(^1) NPs,(^2) Clinical Nurse Specialists, Certified Registered Nurse Anesthetists(^3)</td>
<td>✗ Clinicians, groups that fall under low volume threshold, increase in 2018:</td>
</tr>
<tr>
<td>✓ Groups that include any of the above clinicians</td>
<td>• $90,000 or less in Medicare charges</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>• 200 or fewer Medicare patients</td>
</tr>
<tr>
<td></td>
<td>✗ Providers in their first year billing Medicare</td>
</tr>
</tbody>
</table>

807K
Total clinicians impacted by MACRA

540K
Excluded clinicians from MIPS

622K
Clinicians who must report MIPS

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1) PAs = Physician assistants.
2) NPs = Nurse practitioners.
3) We note that additional provider types are included for APM track qualification: certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists; and a group that includes these professionals.

Source: CMS; Advisory Board research and analysis.
Final Rule Aims to Ease Burden for Small Groups

CMS¹ Highlighting Flexibility, Ease of Reporting as Key Goals

Augmenting MIPS scoring for small practices

- Small practices defined as those with 15 or fewer ECs¹
- Five-point bonus to MIPS score, awarded to small groups that report at least one category in 2018
- Easing requirements for specific MIPS categories in 2018

Offering virtual group reporting option

- TINs² with 10 or fewer ECs can join together to report as virtual group in 2018; assessed, scored collectively as group under MIPS
- No limit on number of TINs in group; no restrictions on geography, specialty
- Virtual groups must be declared by December 31, 2017

19%
Percent ECs CMS estimates will be part of small groups in 2018

1%
Percent ECs CMS estimates will participate in virtual groups in 2018

---

¹ CMS = Centers for Medicare & Medicaid Services.
² TINs = Tax identification numbers.
QPP Payment Track Determination Unchanged

Must Know First Whether Payment Model Is an Advanced APM

1) QP = Qualifying APM Participant.

1. APM

2. Exempt from MIPS

3. MIPS APM Scoring Standard

4. MIPS

Source: Advisory Board research and analysis.
Key Takeaways from the 2018 QPP Final Rule

Advanced Alternative Payment Models (Advanced APM)

Merit-Based Incentive Payment System (MIPS)

Action Items
Two Requirements to Qualify for the APM Track

Must Be in an Advanced APM, and Be a Qualifying Participant

1. Participate in an Advanced APM?
   - YES
   - NO

2. Meet QP Threshold?
   - YES
   - NO

3. Optionally Choose MIPS?
   - YES
   - NO

4. Exempt from MIPS
   - MIPS APM Scoring Standard
   - MIPS

Participate in a MIPS APM?

Source: Advisory Board research and analysis.
Advanced APM Track Criteria Unchanged for 2018

New Policies for Forthcoming All-Payer Combination APM Track

Final Medicare Advanced APM Criteria

- Meet revenue-based standard (average of at least 8% of revenues at risk for participating APMs) or
- Meet benchmark-based standard (maximum possible loss must be at least 3% of spending target)
- Certified EHR use
- Quality requirements comparable to MIPS

Required Payments or Patients Thresholds Per Payment Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments through Advanced APMs</th>
<th>Patients in Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2021</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2022</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>2023</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>2024+</td>
<td>75%</td>
<td>50%</td>
</tr>
</tbody>
</table>

May Include Non-Medicare¹

Engage Payers to Determine Future All-Payer Combination APM Track Eligibility

CMS aligned² the Advanced APM criteria under the Medicare option with the forthcoming All-Payer Combination option. Organizations should reach out to their payers in 2018 to assess the payment models that may qualify for this option in QPP Year 3.

1) In all-payer combination option, Medicare Advanced APM volume threshold (i.e., 25% payments, 20% patients) must also be met, in combination with other-payer Advanced APM volumes.
2) Add 8% revenue-based nominal amount standard for 2021 and 2022 payment years in addition to previously established 3% expenditures-based standard.

Source: CMS; Advisory Board research and analysis.
More Opportunities to Participate in Advanced APMs

CMS to Expand List of Qualifying Programs in 2018 and Beyond

**Expanded Medicare Options (2018+)**

- **Accountable Care Organizations**
  CMMI\(^1\) introducing MSSP\(^2\) Track 1+ in 2018; reopening applications for Next Generation ACOs; anticipating Vermont Medicare ACO initiative to qualify

- **Medicare Advantage**
  CMS considering developing model for MA to qualify for the APM track in 2018

- **Medical Home Models**
  CMMI reopening CPC+ applications; exempting round 1 participants from fewer than 50 clinicians requirement

**Anticipated All-Payer Models (2019+)**

- **Medicaid APM or Medical Home**
  Submissions for states and eligible clinicians open and close in 2018

- **CMS Multi-Payer Models**
  Submissions for payers open and close in 2018

- **Medicare Advantage**
  Submissions for payers open and close in 2018

- **Remaining Other Payer Arrangements**
  No submissions open in 2018

### Payers Submit Advanced APM Requests in 2018

To Establish Advanced APM Status for 2019 QP Performance Period

<table>
<thead>
<tr>
<th>Other Payer APM Types</th>
<th>Payer-Initiated Process</th>
<th>Submission Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Authorized Under Title XIX (e.g., Medicaid)</td>
<td>States may submit request for both Medicaid fee-for-service and Medicaid managed care plan payment arrangements</td>
<td>Jan 1 to Apr 1</td>
</tr>
<tr>
<td><strong>2</strong> Aligned with CMS Multi-Payer Model</td>
<td>Payers with payment arrangements aligned with a CMS Multi-Payer Model may submit request; In models where a state prescribes uniform payment arrangements across all payers statewide, the state would submit on behalf of payers</td>
<td>Jan 1 to Apr 1</td>
</tr>
<tr>
<td><strong>3</strong> Medicare Health Plan (e.g., Medicare Advantage)</td>
<td>Payers may submit request during the same timeframe as the annual Medicare Advantage bid process</td>
<td>Apr to June</td>
</tr>
<tr>
<td><strong>4</strong> Remaining Other Payer Models</td>
<td>Payers not included above, including commercial and other private payers, are not eligible to submit request for the 2019 QP Performance Period</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

1) The deadlines are different between payer types. CMS also allows an EC-initiated process (that includes requests from APM entities), and submission periods occur later than the payer-initiated process.

Source: CMS; Advisory Board research and analysis.
1. Key Takeaways from the 2018 QPP Final Rule

2. Advanced Alternative Payment Models (Advanced APM)

3. Merit-Based Incentive Payment System (MIPS)

4. Action Items
Several Paths Toward MIPS

Majority Will Participate in MIPS; Some Receive Preferential Scoring

1. APM
2. Exempt from MIPS
3. MIPS APM Scoring Standard
4. MIPS

Meet QP Threshold?

Meet Partial QP Threshold?

Participate in an Advanced APM?

Participate in a MIPS APM?

Optionally Choose MIPS?

YES

YES

NO

NO

YES

NO

YES

NO

YES

NO

YES

NO

NO

NO

Source: Advisory Board research and analysis.
<table>
<thead>
<tr>
<th>Category</th>
<th>Key Policies Finalized</th>
<th>Weight¹</th>
</tr>
</thead>
</table>
| Quality               | • Six measures still required for most submission methods  
• Reporting period increases to full calendar year  
• Cap maximum points available for six topped-out measures  
• Data completeness requirement increases to 60% for EHR, registry, and claims-based submission methods                                                                                                                                                                               | Decrease to: 50% |
| Cost                  | • Based on claims data; no additional reporting required  
• Assessed on Medicare Spending per Beneficiary (MSPB) and total per capita cost measures  
• Episode-based measures to be proposed in future rulemaking  
• Ramps up to legally-mandated 30% weight in 2019                                                                                                                                                                                                                       | Increase to: 10% |
| Improvement Activities | • No change to 90-day reporting  
• Additional activities to choose from  
• Majority of practices must be PCMH² to receive full group credit                                                                                                                                                                                                                       | No Change: 15% |
| Advancing Care Information | • No change to 90-day reporting period  
• 2014 CEHRT³ and ACI Transition measures still allowed; bonus for using 2015 Edition CEHRT only to report ACI measures  
• Public health reporting flexibility for ECs who do not engage with Immunization Registries  
• More ECs may qualify for reweighting or hardship exceptions  
• Effective 2017 and beyond, prior MU exclusions available for certain Base Score measures                                                                                                                                               | No Change: 25% |

1) Different weights apply to MIPS APM scoring standard; 2) PCMH = Patient-Centered Medical Homes; 3) CEHRT = Certified Electronic Health Record Technology.
MIPS Data Submission Options Unchanged

Reporting Method Can Differ Among Categories, But Not Within A Category

MIPS Data Submission Methods: Report Individually or as a Group

<table>
<thead>
<tr>
<th>Submission Methods</th>
<th>Qualified Registry</th>
<th>QCDR (^1)</th>
<th>EHR</th>
<th>CMS Web Interface (^2)</th>
<th>Attestation</th>
<th>Claims (^3)</th>
<th>CAHPS Vendor (^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ACI</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Key MIPS Reporting Considerations

- **Reporting Method**
  - Different reporting methods may be used between performance categories
  - Same reporting method is required within a given category in 2018; flexibility to report measures within a category via multiple methods postponed

- **Reporting Period**
  - Different reporting periods may be used between performance categories
  - Full-year 2018 reporting period required for Quality
  - 90-day reporting period allowed for Improvement Activities and ACI

---

1) QCDR = Qualified Clinical Data Registry; 2) CMS Web Interface reporting available for groups of 25 or more only; 3) Claims-based Quality measure data submission available for individual reporting only; 4) CAHPS = Consumer Assessment of Healthcare Providers and Systems available for groups only; must be a CMS-approved survey vendor for MIPS.

Source: CMS; Advisory Board research and analysis.
All MIPS APMs Now Measured on Quality in 2018

Different Category Weights Apply to ECs in MIPS APMs

Comparison Between Default MIPS Category Weights¹ and Scoring Standard for MIPS APMs in 2018

<table>
<thead>
<tr>
<th>MIPS</th>
<th>MIPS APM Scoring Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Improvement Activities (IA)</td>
</tr>
<tr>
<td>Cost</td>
<td>Advancing Care Information (ACI)</td>
</tr>
</tbody>
</table>

**Number of MIPS APM Quality Measures**

<table>
<thead>
<tr>
<th></th>
<th>15</th>
<th>21</th>
<th>16</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO²</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPC+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive ESRD³ Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology Care Model</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**MIPS APM Scoring Standard Applies to Two MIPS EC Scenarios**

1) Below QP⁴ Volume Threshold in Certain Advanced APMs⁵
2) Any Volume in MIPS APMs

**Comprehensive List of APMs**
Reference MIPS APMs at [qpp.cms.gov](http://qpp.cms.gov)

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¹ Cost category will increase to 30% in future years in MIPS and Quality will decrease to 30%. However, Cost performance is not included under the MIPS APM scoring standard.

² Next Generation ACOs and MSSP ACOs report 14 CMS Web Interface Quality measures; final rule adds CAHPS for MIPS Survey to Quality scoring starting 2018.

³ ESRD = End-stage renal disease.

⁴ Includes Partial QPs that elect to participate in MIPS, and all ECs who fall below the Partial QP volume thresholds.

⁵ Not all Advanced APMs meet the definition of a MIPS APM (e.g., episode payment models are Advanced APMs, but not MIPS APMs).

Source: CMS; Advisory Board research and analysis.
| 1 | **Other MIPS APMs** | The MIPS final score for “Other MIPS APMs,” like CPC+, will include **Quality performance** based on data reported under the APM arrangement |
| 2 | **MSSP and Next Generation ACOs** | The Quality category score is expanded to include the **CAHPS for ACO measure**, in addition to CMS Web Interface measures |
| 3 | **MSSP ACOs** | An **additional December 31 snapshot** date will extend the MIPS APM scoring standard to providers that join the ACO after August 31 |

Source: CMS; Advisory Board research and analysis.
MIPS: A Zero-Sum Game for Clinicians

Stronger Performers Benefit at Expense of Those with Low Scores/No Data

Payment Adjustment Determination

1. ECs assigned score of 0–100 based on performance across three categories

2. Score compared to CMS-set performance threshold (PT); non-reporting groups given lowest score

3. A score above PT results in upward payment adjustment; a score below PT results in a downward adjustment

Maximum EC Penalties and Bonuses

Dashed light gray line reflects up to 10% additional incentive for exceptional performers

Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool

QPP Year 2 PT Increases; New Bonuses Points Available

- MIPS final score of 15 avoids a negative payment adjustment, and 70 earns the exceptional performance bonus
- New 2018 MIPS bonus points: small group and complex patient

1) Payment adjustment size corresponds with how far the score deviates from the PT.
2) Additional pool of $500M available for exceptional performers to receive additional incentive of up to 10% for MIPS-eligible providers that exceed the 25th percentile above the PT.

Source: CMS; Advisory Board research and analysis.

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Ease of Avoiding Penalties May Mean Light Bonuses
But Low Bar Rises Quickly After 2018

Hypothetical 2020 MIPS Payment Adjustments
Based on CMS Example of 2018 Provider Score Distribution

Performance Threshold met to avoid penalty
Additional Adjustment Threshold met by full reporting, strong performance
Positive adjustment scaled down for budget neutrality

604K
Estimated number of MIPS eligible clinicians

2.9%
Estimated\(^1\) percentage of MIPS ECs with penalties

74.4%
Estimated\(^1\) percentage of ECs with exceptional performance

$500M
Additional funds to be distributed to ECs above Additional Adjustment Threshold

1) CMS estimate assumes at least 90% of ECs within each practice size category would participate in quality data submission.

Source: CMS; Advisory Board research and analysis.
1. Key Takeaways from the 2018 QPP Final Rule
2. Advanced Alternative Payment Models (Advanced APM)
3. Merit-Based Incentive Payment System (MIPS)
4. Action Items
Three Key Considerations for Near-Term and Future Success

1. **Build Effective Governance**
   - Establish your QPP “dream team”
   - Break down department-specific siloes
   - Monitor changes regularly to refine QPP strategy

2. **Prioritize Performance Improvement in 2018**
   - Focus on Quality and Cost performance
   - Determine which ACI measure set to report
   - Maximize available bonus points in MIPS

3. **Evaluate Future Path in QPP**
   - Expect MIPS to become more challenging quickly
   - Plan for policies finalized to begin in 2019
   - Submit public comment to make your voice heard

Source: Advisory Board research and analysis.
Quality Reporting Is a Team Sport

Collaboration Required to Drive Quality Reporting Success

Key Players in Quality Reporting Governance Structure

Policy Experts
- Monitor regulatory changes and determine strategic and operational implications
- Educate leadership and front-line staff on relevant policies

Clinical and Operational Leaders
- Provide input to measure selection and clinical workflows
- Communicate performance to all relevant stakeholders
- Develop strategies to improve performance and drive staff adoption

IT Department
- Implement and configure IT systems to optimize data collection
- Support data extraction, mapping, consolidation, and reporting
- Provide technical guidance on performance reports

Finance and Health Information Management
- Understand and forecast reimbursement implications
- Optimize coding practices to support accurate documentation

Source: Advisory Board research and analysis
Detailed Resources Available in Appendix

Included in Today’s Presentation Slides

Appendix

2018 QPP Final Rule

Acronyms List

Other Payer Advanced APM Determination Guides

2018 MIPS Performance Category Guides

Quality and Cost Improvement Scoring

Pocket Guides for 2017 and 2018 MIPS ACI Measures

Updated MIPS APM Reporting Requirements
Key Determinants of High-Performing ECs

Together, Quality and Cost Account for 60% of MIPS Final Score in 2018

2. Prioritize Performance Improvement in 2018

Quality Assessment Intensifies

- Reporting period increases to a full calendar year
- Data completeness threshold increases to 60% for EHR, Qualified Registry, QCDR, and claims reporting methods
- Performance score for six highly topped-out measures capped at 7 points

Cost Measurement Begins

- Performance based on full calendar year claims data; no additional reporting required
- Includes two measures: Medicare Spending per Beneficiary and Total Per Capital Cost
- Evaluates Medicare Part A and Part B costs

Source: Advisory Board research and analysis.
Reassess Quality Strategy Against 2018 Changes

Stay the Course with ACI and IA Reporting Approach

1) Report Full-Year Quality Data
   - Assess whether to report full-year data in 2017 to prepare for 2018 requirement
   - Maximize your potential positive payment adjustment by improving performance
   - Satisfy data completeness requirement; threshold increases to 60% for EHR, Qualified Registry, QCDR, and claims submission\(^1\)

2) Reassess Topped-out Measures
   - Review topped-out measures annually
   - Replace measures subject to capped score in 2018 immediately (best long-term approach)
   - Consider alternative reporting mechanism if measure is designated as topped-out with existing mechanism (potential short-term approach)

3) Earn Year-over-Year Improvement Score
   - Meet minimum reporting requirements in 2018 to earn improvement score
   - Boost performance to increase measure achievement score and receive improvement score
   - Build clinician performance improvement incentives into MIPS strategy

\(^1\) All payer data required for EHR, Qualified Registry, and QCDR.
Topped-out, Then Phased-out Quality Measures

Four-Year Timeline for Capped Scoring and Removal

**Identification**
First year a measure is deemed topped-out, same scoring as other measures

**Scoring Capped**
Measure capped at 7 points in the second year of topped-out status

**Removal Considered**
Capped scoring continues, may be proposed for future removal

**Removed**
If removal finalized in rulemaking, no longer available for MIPS reporting

---

**Year 1**

**Year 2**

**Year 3**

**Year 4**

---

**Scoring Cap Begins in 2018 for Six “Highly Topped-out” Measures**

<table>
<thead>
<tr>
<th>Maximum Score Capped at 7 out of 10 Achievement Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perioperative Care: Selection of Prophylactic Antibiotic - First or Second Generation Cephalosporin</td>
</tr>
<tr>
<td>2. Melanoma: Overutilization of Imaging Studies in Melanoma</td>
</tr>
<tr>
<td>3. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in All Patients)</td>
</tr>
<tr>
<td>4. Image Confirmation of Successful Excision of Image-Localized Breast Lesion</td>
</tr>
<tr>
<td>5. Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description</td>
</tr>
<tr>
<td>6. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy</td>
</tr>
</tbody>
</table>

**Scoring Cap Applies to All Topped-out Measures Starting 2019, per Timeline**

**Percentage of Topped-out Measures**

45% Approximate percent of quality measures currently topped-out

**Variation by Reporting Method**

<table>
<thead>
<tr>
<th>Claims</th>
<th>Registry/QCDR</th>
<th>EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%</td>
<td>45%</td>
<td>10%</td>
</tr>
</tbody>
</table>

---

1) Topped-out measure policies do not apply to CMS Web Interface measures.
2) "Highly topped-out" is defined as: measures with no difference between decile 3 through decile 10; process measures only; MIPS measures only (i.e., not QCDR-specific measures); topped-out for all reporting methods; in a specialty set with at least 10 measures.
3) For highly-topped-out measures, timeline applies starting with 2017 benchmarks as Year 1; for all other topped-out measures, timeline applies starting with 2018 benchmarks as Year 1, and so forth. If the measure benchmark is not topped out during one of the first three consecutive years, then the lifecycle would stop and start again at year 1 the next time the measure benchmark is topped out.
4) Based on 2015 historic benchmark data.

Source: CMS; Advisory Board research and analysis.
Improvement Scoring Component Finalized for Quality and Cost

Overview of Improvement Scoring Methodology

- **Quality**:
  - Improvement measured at the category level
  - Compare Year 1 and Year 2 achievement scores
  - Assess relative percent increase in achievement score

- **Cost**:
  - Improvement measured at the measure level
  - Compare Year 1 and Year 2 achievement scores
  - Assess relative number of improved measures versus declined

- Improvement can be assessed even when measures reported change from year to year

- Improvement can only be assessed on the same cost measure(s) from year-to-year

Source: CMS; Advisory Board research and analysis.
Cost Measurement Begins in 2018

Assesses Medicare Part A and Part B Costs

Two Measures Contribute to Score in 2018

1. **Total Cost per Capita:**
   Specialty-adjusted measure; includes all payments under Medicare Parts A and B

2. **Medicare Spending per Beneficiary:**
   Cost of Medicare Part A and B services 3 days before and 30 days after inpatient admission

---

Our Best Tips for Managing Total Cost

- **Prioritize risk adjustment**
  Improve HCC¹ capture to reduce impact of complex patients on score

- **Develop a short-list of top cost-savings opportunities**
  Evaluate cost performance in post-acute, drug spend, OP,² IP³

---

¹ HCC = Hierarchical Conditions Category
² OP = Outpatient.
³ IP = Inpatient.

---

See our Playbook for Maximizing Your Performance in MACRA for more detail: advisory.com/MACRA

---

Source: CMS; Advisory Board research and analysis.
Which ACI Measure Set Should I Report?

Consider Performance and Technology in Your Decision

1) One-time bonus available if ECs exclusively use 2015 Edition CEHRT to report Stage 3-aligned ACI measures in 2018.

Performance:
Can you earn full ACI credit using the Modified Stage 2-aligned ACI Transition Measures?

Yes

Report Modified Stage 2-aligned ACI Transition Measures
(Also Monitor Stage 3-aligned ACI Measures)

No

Technology:
Is 2015 Edition CEHRT fully implemented to report Stage 3-aligned ACI measures?

No

Performance:
Do Stage 3-aligned ACI Measures (including 10% bonus\(^1\)) score higher than Modified Stage 2-aligned ACI Transition Measures?

No

Lower performance on the more difficult ACI Measures may dilute the benefit of the 10% bonus

Yes

Performance:
Can you earn full ACI credit using the Stage 3-aligned ACI Measures?

Yes

Report Stage 3-aligned ACI Measures

Source: CMS; Advisory Board research and analysis.
Maximize MIPS Performance with Bonus Points

New Types of Bonus Points Available in 2018

**Quality Bonus – up to 20%**

- Report additional high-priority measures beyond one required outcome measure
  - Earn up to 10% of total possible points in the Quality category denominator
- Use end-to-end electronic reporting to submit measures
  - Earn up to 10% of total possible points in the Quality category denominator

**ACI Bonus – up to 25%**

- Engage in additional public health reporting beyond performance score
  - Earn 5% toward 100 ACI points
- Use CEHRT to carry out Improvement Activities
  - Earn 10% toward 100 ACI points
- **New!** Use 2015 Edition CEHRT exclusively and report ACI Measures
  - Earn 10% toward 100 ACI points

**New! Two Types of Bonuses Applied to Composite MIPS Final Score**

**Small Practice – 5 points**

- Practices with 15 or fewer ECs
- Group size based on number of NPIs associated with a TIN, before MIPS exclusions are applied

**Complex Patients – up to 5 points**

- Two-component bonus based on:
  - Average HCC risk score, as indicator of medical complexity
  - Dual eligible ratio, as indicator of social risk

---

1) Measure must meet case minimum and data completeness requirements, and performance must be above zero. One point for each additional appropriate use, patient safety, efficiency and care coordination measure. Two points for each additional outcome and patient experience measure.

2) One point for each measure submitted using end-to-end electronic reporting. Data must be captured in CEHRT and submitted to CMS electronically, either directly or through a third-party intermediary without manual manipulation.

3) NPI = National Provider Identifier.

Source: CMS; Advisory Board research and analysis.
3. Evaluate Future Path in QPP

Stakes Legally-Mandated to Increase in 2019

MIPS Set to Get Tougher by Law, by Design

4% at risk
Low performance bar, multiple reporting period options, Cost category weight at 0%

5% at risk
Few changes, with most Year 1 flexibilities retained:
- Year-long reporting period for Quality
- Cost category increases to 10%
- Retain Year 1 ACI measure and CEHRT requirements

7% at risk
MACRA-mandated changes take place, expect fewer flexible options, with more challenging requirements:
- **Quality**
  - Full-year reporting period, and potentially higher data completeness thresholds
- **Cost**
  - Weight required to increase to 30%, often difficult to inflect improvement
- **ACI**
  - 2015 Edition CEHRT upgrade required to report Stage 3-equivalent, more difficult measures

Source: CMS; Advisory Board research and analysis.
Certain MIPS Policies Not Finalized for 2018

Delayed, But Not Forgotten

“Mix and Match”
Multiple Reporting Methods

Enables Greater MIPS Reporting Flexibility

- Report measures within a given performance category via multiple methods
- Opportunity to more easily “test out” new reporting options while maximizing performance
- Benchmarks and topped-out status often differ between reporting methods

Facility-Based MIPS Scoring Option

Connects Hospital Inpatient VBP Performance to MIPS

- Hospital-VBP score used to calculate MIPS Quality and Cost scores
- Facility-based designation applies to:
  - ECs that furnish 75% or more covered professional services in an inpatient hospital or ED setting
  - Groups with 75% or more of ECs eligible for facility-based measurement as individuals

Episode-Based Cost Measures

Measures Cost to Medicare During an Episode of Care

- MACRA requires cost measures to consider patient condition groups and care episode groups
- Like other cost measures, performance is based on claims data; no additional MIPS reporting required
- “Field testing” conducted on eight measures

Finalized for Implementation in 2019; Providers Should Monitor Future Rulemaking

1) VBP = Value-Based Purchasing (Program); 2) ED = Emergency department.

Source: Advisory Board research and analysis.
Make Your Voice Heard

CMS Seeks Feedback for 2018 Final Rule with Public Comment Period

Key Considerations for Public Comment

- **Extreme and uncontrollable circumstances.** Support automatic penalty-exemption for affected ECs in 2017, and offer input on policy for future years

- **Other Payer APMs.** Provide feedback on whether Advanced APM determinations should apply for multiple years

- **MIPS low-volume threshold.** Comment on whether threshold should be applied at group-level, or only individual-level

- **MIPS group definition.** Suggest additional ways to define a group beyond TIN-based designation alone

- **MIPS scoring.** Recommend ways to simplify the scoring system and align policies across categories

- **Quality.** Suggest shorter than year-long reporting period for 2018, and ask for clarification on how data completeness will be assessed for all payer data

- **Facility-based ECs.** Provide feedback on notification and opt-out process for providers automatically assigned a facility-based score

---

Set Aside Resources to Review and Comment on Annual QPP Rulemaking

- **April - June**
  - Annual QPP proposal published

- **January**
  - Performance period begins 2 months after requirements finalized

- **November**
  - Annual QPP Final Rule published

---

Public comment closes on **January 1, 2018** for the 2018 QPP final rule with comment period

---

Source: Advisory Board research and analysis.
Key Takeaways from the 2018 QPP Final Rule

Quality Payment Program Framework Preserved

APM track policies remain largely unchanged; notable new MIPS flexibilities introduced

Most Providers Still Avoid Penalty in 2018

Reassess MIPS Quality and Cost strategy to maximize performance and avoid penalties in future years

Plan for Future Rulemaking and Audits

Providers should submit public comment to help shape the future of the program and prepare for audits

Get Your House in Order

- Reference our 2017 MIPS Audit Checklist to prepare your documentation
- Use our 2017 MIPS Score Estimator to assess your performance
## MACRA Resources to Support You

### Webconferences
- 2018 MACRA Final Rule Detailed Analysis
- MACRA: How the 2018 QPP Final Rule Impacts Providers
- 2017 MACRA Final Rule Detailed Analysis
- MACRA: How the Final Rule Impacts Providers
- The No-Regrets Approach to MACRA
- Rethinking Your Medicare Risk Strategy Under MACRA

### Tools
- Guide to MIPS Participation and Special Statuses
- 2017 MIPS Final Score Estimator
- 2017 MIPS Audit Checklist
- 2017 MIPS Measures List

### Research
- 6 experts on what the 2018 MACRA final rule means for you
- 10 takeaways on the 2018 MACRA Final Rule
- Playbook for Maximizing Performance in MACRA

For These and Forthcoming Resources on MACRA
https://www.advisory.com/macra

Source: Advisory Board research and analysis.
The Advisory Board’s Suite of MACRA Solutions

Targeted Offerings to Meet Your Organization’s Needs

<table>
<thead>
<tr>
<th>Research Memberships</th>
<th>MACRA Intensive</th>
<th>Quality Reporting Roundtable</th>
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</thead>
<tbody>
<tr>
<td>• Publications, web conferences, and blog posts that cover the key requirements of MACRA and implications for providers</td>
<td>• On-site session designed to identify readiness gaps and develop implementation strategy</td>
<td>• Service to help providers navigate quality reporting programs requirements, including MACRA and Meaningful Use</td>
</tr>
<tr>
<td>• On-site policy briefing available for key stakeholders</td>
<td>• Three parts: policy education; performance assessment; and strategic discussion with leadership</td>
<td>• On-call experts, policy monitoring, audit support, best practices, and networking opportunities</td>
</tr>
</tbody>
</table>

Additional Custom Strategic Support Available

• Hands-on support to help organizations design and implement large-scale business transformation needed for health care reform
• Areas of expertise include value-based payment models, physician alignment, and EHR optimization
Ask a Question

To ask a question, please type it into the “Questions” box on your GoTo panel and press “Send.”
Webconference Survey

Please take a minute to provide your thoughts on today’s presentation.

Thank You!

Please note that the survey does not apply to webconferences viewed on demand.
Appendix

2018 QPP Final Rule
Commonly Used Acronyms

- **ACI**: Advancing Care Information
- **ACO**: Accountable care organization
- **Advanced APM**: Alternative payment models potentially eligible for APM track incentives
- **APM**: Alternative Payment Model
- **CAHPS**: Consumer Assessment of Healthcare Providers and Systems
- **CEHRT**: Certified Electronic Health Record Technology
- **CMS**: Centers for Medicare & Medicaid Services
- **CPC+**: Comprehensive Primary Care Plus
- **EC**: Eligible clinician in the CMS Quality Payment Program under MACRA
- **EPM**: Episode Payment Model
- **IA**: Improvement Activities
- **MACRA**: Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015
- **MIPS**: Merit-Based Incentive Payment System
- **MIPS APM**: Certain APMs that qualify for special MIPS scoring
- **MSSP**: Medicare Shared Savings Program
- **MU**: Meaningful Use
- **PCMH**: Patient-Centered Medical Home
- **PQRS**: Physician Quality Reporting System
- **QCDR**: Qualified Clinical Data Registry
- **QP**: Qualifying APM Participant
- **QPP**: Quality Payment Program implemented by MACRA
- **VBPM**: Value-Based Payment Modifier

Source: Advisory Board research and analysis.
Decoding the Other-Payer AAPM¹ Eligibility Process

Most Commercial Payers Not Included in First Phase Determinations

General Process for Payers² to Request Other Payer AAPM Determination

1. Application and instructions made available
2. CMS determines whether payer model is eligible
3. CMS posts list of eligible payer models

Guidance

Application submitted by deadline

Submission

Determination

Notification

Posting

QPP Year 3 Payers Eligible for First Phase Determination
- Title XIX (i.e., Medicaid)
- CMS Multi-Payer Models (e.g., CPC+)
- Medicare Health Plans (e.g., Medicare Advantage)

Information Requested in 2018 by CMS for Year 3 Other AAPM Determination
1. Model name
2. Model description
3. Term of the model
4. Locations where model operates
5. Participant eligibility
6. Evidence to support how the APM criteria are met

1) AAPM = Advanced Alternative Payment Model.
2) The deadlines are different between payer types. CMS also allows an EC-initiated process (that includes requests from APM entities), and submission periods occur later than the payer-initiated process.

Source: CMS; Advisory Board research and analysis.
Other Payer Advanced APM Determination Timeline

Process Begins in 2018 for the 2019 QP Performance Period

- **Authorized Under Title XIX (e.g., Medicaid)**
  - State-initiated process
  - Submission Period
  - CMS Posts AAPM List

- **Aligned with CMS Multi-Payer Model**
  - Payer-initiated process
  - Submission Period
  - CMS Posts AAPM List

- **Medicare Health Plan (e.g., Medicare Advantage)**
  - Payer-initiated process
  - Submission Period
  - CMS Posts AAPM List

- **Remaining Other Payer Models**
  - Payer-initiated process is not available for 2019 QP Performance Period, to be implemented for 2020 QP Performance Period

- **Other Payer Alternative Payment Model Types**
  - An EC may request QP determination at the EC level;
  - An APM Entity may request QP determination at the APM Entity level

Source: CMS; Advisory Board research and analysis.
2018 MIPS Quality Performance Category

Many 2018 Changes Affect Quality Scoring; Time to “Double Down”

Category in Brief: Quality

- Full-year reporting period in 2018
- Report at least six measures, including one outcome measure
- 60% all-payer data completeness requirement for 2018
- Year-over-year category-level performance improvement rewarded
- Four-year timeline for removal of topped-out measures
- Scoring policies and number of CMS Web Interface measures differ from other reporting mechanisms

How Scoring Works

<table>
<thead>
<tr>
<th>Achievement</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>10 Pts</th>
<th>7 Pts</th>
<th>3 Pts</th>
<th>1 Pts</th>
<th>10 Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Measure 3</td>
<td>Topped out</td>
<td>Class 2</td>
<td>Class 3</td>
<td>All-Cause</td>
<td>Readmissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Measures Reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

!! Two Types of Bonuses

- Up to 10% Pts
- Up to 10% Pts
- Up to 10% Score

- Additional high-priority measures
- End-to-end electronic reporting

Improvement

Scoring Takeaways

- In general, each measure is worth up to 10 achievement points based on peer benchmark; 7-point cap for six highly topped-out measures in 2018
- Two types of bonus points each capped at 10% of the total possible points in the denominator
- Additional improvement score up to 10% for category-level improvement compared to prior year performance
- Earn 3 points measures below case minimum threshold, 7 no benchmark, or 0% performance
- Measures that do not meet data completeness requirements earn 1 point only; 3 points for small groups

Source: CMS; Advisory Board research and analysis.
Quality Performance Improvement Scoring

Rewards Category-Level Year-over-Year Improvement in Two Steps

1. Example of Quality Category Improvement Scoring Calculation

- **30** Achievement Points\(^1\)  
  - **60** Possible Points

- **50% Year 1** Category Achievement Percent Score\(^2\)

- **42** Achievement Points

- **70% Year 2** Category Achievement Percent Score\(^3\)

- **50% Year 1** Category Achievement Percent Score

- **20% Increase in Achievement**

- **10% Improvement Percent Score\(^5\)** (i.e., Year 2 reward)

2. Determine Year 2 Quality Category Percent Score

- **42** Achievement Points

- **6** Bonus Points

- **4% Improvement Percent Score\(^6\)

- **84% Year 2 Quality Category Percent Score**

Source: CMS; Advisory Board research and analysis.

1) Achievement points earned across all measures based on peer benchmarks; do not include bonus points.
2) Assumes 6 applicable measures, for a total of 60 points in the category denominator.
3) If Year 1 Quality category achievement percent score is below 30% (i.e., lowest score possible with complete reporting in 2017), CMS will substitute 30% to calculate the improvement percent score.
4) To receive Quality improvement percent score, full Year 2 participation required (i.e., reports all required measures and meets data completeness for full-year performance period in 2018).
5) Maximum Quality improvement percent score is capped at 10%, and cannot be negative (i.e., lower than 0%). Improvement score does not apply to facility-based scoring option.
6) Category percent score capped at 100%.
2018 MIPS Cost Performance Category

Increases to 10% Weight in 2018; Episode Measures Yet to Be Determined

How Scoring Works

<table>
<thead>
<tr>
<th>Achievement</th>
<th>10 Points</th>
<th>10 Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total per Capita Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring Takeaways

- Measures are equally weighted for up to 10 achievement points each based on peer benchmark
- A measure is included in scoring only if case minimum threshold is met; total possible points can vary between ECs
- Additional improvement score up to 1% for measure-level improvement compared to prior year performance starting 2019
- 2017 cost performance will be provided to ECs for informational purposes

HCC Coding Critical to Accurate Risk Adjustment in Cost Performance

Reference our resource on Three Steps for Optimizing HCC Capture (February 2016)

Category in Brief: Cost

- Included in 2018 MIPS final score; 10% category weight¹
- Steep ramp up to 30% in 2019, as required by law¹
- 2018 cost performance based on:
  - Total per Capita Cost
  - Medicare spending per beneficiary (MSPB)
- CMS will use data submitted through administrative claims to determine performance; no additional reporting required
- Case minimum threshold is 20 for Total per Capita Cost and Episode-Based measures; 35 for MSPB
- Eight episode-based measures currently being field tested for potential inclusion in a future year

¹ Cost category is not included in MIPS APM scoring standard.
Understand the Cost Measures

Breaking Down Attribution, When Your Group Is Accountable

**Total Cost per Capita**

**Definition:**
Specialty-adjusted measure that evaluates overall efficiency of care. Includes all payments under Medicare Parts A and B

- Medical group must have minimum 20 cases or not scored

**Attribution Method:**
Two-step process

*#1:* Attributed to group with largest share of primary care services provided by PCPs

*#2:* If beneficiary didn’t visit PCP, attribution applied to specialist with plurality of services

**Medicare Spending per Beneficiary**

**Definition:**
Cost of Medicare Part A and B services during an episode defined as three days before and 30 days after inpatient hospitalization

- No longer specialty-adjusted
- Medical group must have minimum 35 cases or not scored

**Attribution Method:**
Attributed to TIN that provides plurality of claims for Medicare Part B Services during inpatient hospitalization

---

**Evaluate QRUR cost performance**

See [CMS website](https://www.cms.gov) for instructions to obtain your QRUR

---

1) As measured by allowable charges.
2) QRUR = Quality and Resource Use Report.
Cost Performance Improvement Scoring

Rewards Measure-Level Year-over-Year Improvement in Two Steps

1. Example of Cost Measure Improvement Scoring Calculation

   Two Cost Measures Applicable
   
   **8.2**
   
   P
   
   **6.4**
   
   Significant Improvement
   
   **6.4**
   
   No Improvement and No Decline
   
   **8.2**
   
   Year 2
   
   **0.5% Improvement Percent Score**
   
   **73% Year 2 Cost Category Percent Score**

2. Determine Year 2 Cost Category Percent Score

   **73.5% Year 2 Cost Category Percent Score**

   Factor against category weight to determine MIPS final score contribution

3. Improvement Scoring Begins in 2019 Performance Year

   Measures are eligible for improvement scoring the second year they are included in MIPS, and are assessed only when provider participates in MIPS using the same group or individual identifier in two consecutive years

Source: CMS; Advisory Board research and analysis.

---

1) Significant improvement or decline between performance periods determined using t-test statistical methodology.
2) Maximum Cost improvement percent score is capped at 1%, and cannot be negative (i.e., lower than 0%). Improvement score does not apply to facility-based scoring option.
3) Assumes 2 applicable measures, for a total of 20 points in the category denominator.
4) Category percent score capped at 100%.
2018 MIPS IA Performance Category

90-day Reporting Period in 2018; New PCMH Group Reporting Threshold

Two Measure Types

- **High-weighted activity:** 20 points
- **Medium-weighted activity:** 10 points

New High-Weighted Activities

- Provide Education Opportunities for New Clinicians
- Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients
- Patient Navigator Program
- CDC\(^1\) Training on CDC’s Guideline for Prescribing Opioids for Chronic Pain
- Completion of CDC Training on Antibiotic Stewardship
- Consulting AUC\(^2\) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging
- Percutaneous coronary intervention (PCI) bleeding campaign

How Scoring Works

- **Achieve 40 points for full credit**
  - Any combination of high-weighted or medium-weighted activities
  - Small, rural, HPSA\(^3\) practices, and non-patient-facing ECs earn double points per activity
  - PCMH\(^4\) earns full credit; MIPS APM earns at least half credit\(^5\)

<table>
<thead>
<tr>
<th>Example</th>
<th>Reported Activities</th>
<th>Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H H</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>H M M</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>M M M M M</td>
<td>40</td>
</tr>
</tbody>
</table>

**PCMH Group Reporting Threshold**

Starting 2018, more than 50% of practice sites must participate in a PCMH in order for the group to receive full IA credit

---

1) CDC = Centers for Disease Control and Prevention.
2) AUC = Appropriate Use Criteria.
3) HPSA = Health Professional Shortage Areas.
4) PCMH = Patient-Centered Medical Home.
5) CMS will assign category score based on MIPS APM-required activities. For example, CMS afforded full credit in 2017; see https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf.
2018 MIPS ACI Performance Category

2015 Edition CEHRT Not Required in 2018; New Bonus Available

How Scoring Works: Two Paths to 100 Points

**Category in Brief: ACI**

1. No change to 90-day reporting period
2. 2014 Edition CEHRT and ACI Transition measures still allowed
3. 10% bonus for exclusive use of 2015 Edition CEHRT to report ACI measures
4. Public health reporting flexibility for ECs who do not engage with Immunization Registries
5. More ECs may qualify for 0% reweighting1 or hardship exceptions2
6. Effective 2017 and beyond, prior MU exclusions available for certain Base Score measures3

**Scoring Components**

**Base Score4**

- Security risk analysis
- Electronic prescribing3
- Provide patient access
- Send a summary of care3
- **ACI measure**: Request/accept summary of care3, 5

**Performance Score6**

- **ACI measures**: 9 available measures
- **ACI Transition measures**: 7 available measures

**Bonus Score**

- 10 points for using CEHRT in IA
- 5 points for additional public health reporting beyond performance score
- **New!** 10 points if only 2015 Edition CEHRT used to report Stage-3 equivalent ACI measures in 2018

---

1) ACI category reweighted to 0% for hospital-based ECs, non-patient facing ECs, advanced practitioners, and ECs who qualify for significant hardship. Starting 2018, POS 19 (off-campus outpatient hospital) added to hospital-based EC definition.
2) New hardship exceptions finalized for Ambulatory Surgical Center (ASC)-based ECs and/or EHR decertification starting 2017, and for small practices starting 2018. CMS will not apply a 5-year limit to hardship exceptions.
3) If exclusion is applicable, a value of 1 in the numerator is not required for the Base Score.
4) Base score requires “Yes” for Security Risk Analysis, and at least 1 in the numerator for all other required measures.
5) Request/accept Summary of Care is required under Stage 3-equivalent ACI measures. This measure is not included for Modified Stage 2-equivalent ACI Transition measures.
6) Performance score based on each measure’s performance rate for percentage-based measures. Additional flexibility finalized to reward public health reporting for ECs who do not engage with an Immunization Registry.

Source: CMS; Advisory Board research and analysis.
### Updated 2017 ACI Transition Measures Pocket Guide

#### Aligned with Modified Stage 2 MU Measures; New Base Score Exclusions

<table>
<thead>
<tr>
<th>Required for Base Score</th>
<th>0% or 10%</th>
<th>5% Bonus³</th>
<th>10% Bonus⁴</th>
</tr>
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<tbody>
<tr>
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<td>Syndromic Surveillance</td>
<td>Specialized Registry</td>
</tr>
<tr>
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</tr>
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<td><strong>Electronic Prescribing¹</strong></td>
<td>Provide Patient Access²</td>
<td>Health Information Exchange¹</td>
<td></td>
</tr>
</tbody>
</table>

### Pocket Guide Legend

- **Red**: Required for the Base score (50%)
- **Blue**: Base exclusion allowed
- **Dark Grey**: Contributes toward Performance
- **Light Grey**: Contributes toward Bonus

---

1) Legacy MU exclusion allowed; if applicable, numerator of 1 is not required to earn Base score.
2) All three functionalities (view, download, and transmit - VDT) must be present and accessible to meet the measure.
3) Providers can earn a 5% bonus if they report any of these public health measures.
4) A 10% bonus is awarded in ACI if CEHRT is used to carry out any activity reported in the Improvement Activities category.

Source: CMS; Advisory Board research and analysis; Pocket Guide dated December 12, 2017.
### Updated 2017 ACI Measures Pocket Guide

#### Aligned with Stage 3 MU Measures; New Base Score Exclusions

<table>
<thead>
<tr>
<th>Required for Base Score</th>
<th>0% or 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>Immunization Registry</td>
</tr>
<tr>
<td>Electronic Prescribing(^1)</td>
<td>5% Bonus(^3)</td>
</tr>
<tr>
<td>Provide Patient Access(^2)</td>
<td>Syndromic Surveillance</td>
</tr>
<tr>
<td>Send a Summary of Care(^1)</td>
<td>Electronic Case Reporting</td>
</tr>
<tr>
<td>Request/Accept Summary of Care(^1)</td>
<td>Public Health Registry</td>
</tr>
<tr>
<td>View, Download, or Transmit</td>
<td>Clinical Data Registry</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>10% Bonus(^4)</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>Use CEHRT for Improvement Activities</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td></td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td></td>
</tr>
</tbody>
</table>

**Pocket Guide Legend**

- Required for the Base score (50%)
- Base exclusion allowed
- Contributes toward Performance
- Contributes toward Bonus

---

1) Legacy MU exclusion allowed; if applicable, numerator of 1 is not required to earn Base score.
2) All three functionalities (view, download, and transmit - VDT) and an application programming interface (API) must be present and accessible to meet the measure.
3) Providers can earn a 5% bonus if they report any of these public health measures.
4) A 10% bonus is awarded in ACI if CEHRT is used to carry out any activity reported in the Improvement Activities category.

Source: CMS; Advisory Board research and analysis; Pocket Guide dated December 12, 2017.
## 2018 ACI Transition Measures Pocket Guide

**Aligned with Modified Stage 2 MU Measures**

<table>
<thead>
<tr>
<th>Required for Base Score</th>
<th>Up to 20%</th>
<th>Up to 20%</th>
<th>Up to 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Security Risk Analysis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electronic Prescribing</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provide Patient Access</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Information Exchange</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Up to 10%</th>
<th>Up to 10%</th>
<th>Up to 10%</th>
<th>Up to 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient-Specific Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Secure Messaging</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>View, Download, or Transmit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medication Reconciliation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Legacy MU exclusion allowed; if applicable, numerator of 1 is not required to earn Base score.
2) All three functionalities (view, download, and transmit - VDT) must be present and accessible to meet the measure.
3) Public Health Reporting measures include: Immunization Registry; Syndromic Surveillance; and Specialized Registry.
4) Bonus cannot be earned for reporting to the same agency or registry that is used for earning a performance score.
5) A 10% bonus is awarded in ACI if CEHRT is used to carry out any activity reported in the Improvement Activities category.

**Performance score can be earned with any public health reporting measure, not just Immunization Registry**

- **0% or 10%**
- **Public Health Reporting**
- **5% Bonus**
- **Additional Public Health Reporting**<sup>3,4</sup>
- **10% Bonus**<sup>5</sup>

**Pocket Guide Legend**
- Red: Required for the Base score (50%)
- Gray: Base exclusion allowed
- Black: Contributes toward Performance
- Blue: Contributes toward Bonus

Source: CMS; Advisory Board research and analysis; Pocket Guide dated December 12, 2017.
# 2018 ACI Measures Pocket Guide

## Aligned with Stage 3 MU Measures

<table>
<thead>
<tr>
<th>Required for Base Score</th>
<th>Required for Base Score</th>
<th>Required for Base Score</th>
<th>Required for Base Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security Risk Analysis</td>
<td>Electronic Prescribing¹</td>
<td>Provide Patient Access²</td>
<td>Send a Summary of Care¹</td>
</tr>
<tr>
<td>Up to 10%</td>
<td>Up to 10%</td>
<td>Up to 10%</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>View, Download, or Transmit</td>
<td>Secure Messaging</td>
<td>Patient-Generated Health Data</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>Up to 10%</td>
<td>Up to 10%</td>
<td>Up to 10%</td>
<td>Up to 10%</td>
</tr>
<tr>
<td>Use CEHRT for Improvement Activities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### New! 10% Bonus

Exclusively Use 2015 Edition CEHRT

### Performance Score

- **0% or 10%**
- **Public Health Reporting³**
- **5% Bonus³**
- **Additional Public Health Reporting³,⁴**
- **10% Bonus⁵**

--

1) Legacy MU exclusion allowed; if applicable, numerator of 1 is not required to earn Base score.
2) All three functionalities (view, download, and transmit - VDT) and an API must be present and accessible to meet the measure.
3) Public Health Reporting measures include: Immunization Registry; Syndromic Surveillance; Electronic Case Reporting; Public Health Registry; and Clinical Data Registry.
4) Bonus cannot be earned for reporting to the same agency or registry that is used for earning a performance score.
5) A 10% bonus is awarded in ACI if CEHRT is used to carry out any activity reported in the Improvement Activities category.

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Source: CMS; Advisory Board research and analysis; Pocket Guide dated December 12, 2017.
2018 MSSP ACO MIPS Reporting

MIPS Scored at APM Entity Level; Report ACI at the Group TIN Level

Applies to All MSSP Track 1 ACOs, and Tracks 2 and 3 ACOs Below QP\(^1\) Volume Threshold

Quality (50%)

- Reporting aligned with ACO requirements; **no separate reporting required for MIPS**
- Scored on measures submitted through CMS Web Interface by ACO on behalf of MIPS ECs
- **New!** Category score includes CAHPS for ACO measure starting 2018

Improvement Activities (20%)

- Likely **no additional MIPS reporting** required in 2018
- CMS will assign category score based on ACO-required activities\(^2\)
- In future years, additional reporting may be required by the ACO if the CMS-assigned points do not yield the full category score\(^3\)

ACI (30%)

- Additional MIPS reporting required for this category independent of the ACO
- **Report group data through respective ACO participant billing TINs**
- Scores from all ACO participant TINs are aggregated to yield a weighted average APM Entity group score\(^4\)

1) Also applies to partial QPs that choose to participate in MIPS.
2) For example, CMS awarded full category score in 2017 for MIPS APMs, [https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf](https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf).
3) MIPS APM participants receive at minimum one half of the total possible points.
4) TINs excluded from ACI reporting do not contribute to APM Entity group score.

Staring 2018, CMS finalized a **December 31 snapshot date** that extends the MIPS APM scoring standard to ECs who join an ACO late in the performance year

Source: CMS; Advisory Board research and analysis.
2018 Next Generation ACO MIPS Reporting

MIPS Scored at APM Entity Level; Report ACI at Individual or Group Level

Applies to Next Generation ACO Entities Below QP Volume Threshold

Quality (50%)
- Reporting aligned with ACO requirements; no separate reporting required for MIPS
- Scored on measures submitted through CMS Web Interface by ACO on behalf of MIPS ECs
- New! Category score includes CAHPS for ACO measure starting 2018

Improvement Activities (20%)
- Likely no additional MIPS reporting required in 2018
- CMS will assign category score based on ACO-required activities
- In future years, additional reporting may be required by the ACO if the CMS-assigned points do not yield the full category score

ACI (30%)
- Additional MIPS reporting required for this category independent of the ACO
- ECs can report individual level (NPI/TIN) or group level (TIN) data
- CMS will attribute one score to each MIPS EC, and scores for all MIPS ECs in the APM Entity group are averaged to yield a single APM Entity group score

1) Also applies to partial QPs that choose to participate in MIPS.
2) For example, CMS awarded full category score in 2017 for MIPS APMs, [https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf](https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf).
3) MIPS APM participants receive at minimum one half of the total possible points.
4) The score will be the highest attributable score, which may be derived from either group or individual reporting.

Source: CMS; Advisory Board research and analysis.
2018 Other MIPS APM\(^1\) Reporting in MIPS

Quality Now Included in 2018; MIPS Scored at APM Entity\(^2\) Level

Applies to MIPS APM Entities Below QP\(^1\) Volume Threshold

**New! Quality (50%)**
- MIPS measures aligned with APM requirements; **no separate reporting required for MIPS**
- MIPS scoring applied to measure data submitted by APM Entity on behalf of MIPS ECs

**Improvement Activities (20%)**
- Likely **no additional MIPS reporting** required in 2018
- CMS will assign category score based on APM-required activities\(^3\)
- In future years, additional reporting may be required by the APM Entity if the CMS-assigned points do not yield the full category score\(^4\)

**ACI (30%)**
- Additional MIPS reporting required for this category independent of the APM
- ECs can report individual level (NPI/TIN) or group level (TIN) data
- CMS will attribute one score\(^5\) to each MIPS EC, and scores for all MIPS ECs in the APM Entity group are averaged to yield a single APM Entity group score

### Number of MIPS APM Quality Measures

<table>
<thead>
<tr>
<th></th>
<th>CPC+</th>
<th>Comprehensive ESRD Care</th>
<th>Oncology Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>21</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>

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1) “Other MIPS APM” is defined as a MIPS APM that does not report Quality measures through CMS Web Interface (e.g., CPC+, Comprehensive ESRD Care, and Oncology Care Model).
2) Also applies to partial QPs that choose to participate in MIPS.
3) For example, CMS awarded full category score in 2017 for MIPS APMs, [https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf](https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf).
4) MIPS APM participants receive at minimum one half of the total possible points.
5) The score will be the highest attributable score, which may be derived from either group or individual reporting.

Source: CMS; Advisory Board research and analysis.