Making Sense of MACRA’s Alphabet Soup:
What does it mean for Internal Medicine?
How Can ACP Help?

October 2016
April 2015 – Congress Passed Landmark, Bipartisan Law – MACRA...

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – focused on Part B Medicare
- Congressional Intent of MACRA:
  - Sustainable Growth Rate repeal
  - Improve care for Medicare beneficiaries
  - Change our physician payment system from one focused on volume to one focused on value

**MACRA has been recast as the Quality Payment Program - NPRM April 27, 2016**
Quality Payment Program In a Nutshell

Law *intended* to align physician payment with *value*

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
Or now the...

**Quality Payment Program**

- **Merit-Based Incentive Payment System (MIPS)**
- **Advanced Alternative Payment Models (APMs)**
However, it feels like CMS may be taking a secret code approach to implementation...

We hear you...
https://www.acponline.org/macravideo

HUH?

What’s with the Alphabet Soup of Regulations?
MACRA/QPP Final Rule is Here...

- Published on October 14, 2016: https://qpp.cms.gov/docs/CMS-5517-FC.pdf

- Who will be participating in the Quality Payment Program?
  - NO: If you bill Medicare less than or equal to $30,000 a year OR provide care for less than or equal to 100 Medicare patients a year. (BIG WIN for ACP)
  - NO: If 2017 is your first year participating in Medicare, then you’re not in the MIPS track of the Quality Payment Program.
Merit-based Incentive Payment System (MIPS)
This new MIPS “report card” will replace current Medicare reporting programs

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

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (quality and cost of care)**
- **“Meaningful use” of EHRs**

**MACRA** streamlines those programs into **MIPS**:

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

How will Clinicians be Scored Under MIPS? – FINAL RULE FOR 2019

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

**Year 1 or 2019***

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical practice improvement activities</td>
<td>15%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Based on reporting data in 2017

Getting cost down to 0% in the first year is a BIG WIN for ACP! Exactly what we asked for.
How Much Can MIPS Adjust Payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**.

**MAXIMUM Adjustments**

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-5%</td>
</tr>
<tr>
<td>2020</td>
<td>-7%</td>
</tr>
<tr>
<td>2021</td>
<td>-9%</td>
</tr>
<tr>
<td>2022 onward</td>
<td>4% 5% 7% 9%</td>
</tr>
</tbody>
</table>

**Adjustment to provider’s base rate of Medicare Part B payment**

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)
Timing of QPP Implementation

Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

Source: https://qpp.cms.gov/
BIG CHANGE: Pick Your Pace

- September 8 blog by CMS administrator Slavitt announced major changes to ease transition to new Quality Payment Program, especially for smaller practices, called “Pick your Pace.”
- Physicians and their practices will have the flexibility needed in 2017 to choose their own pace for transitioning to value-based payments.
- This was responsive to ACP’s recommendations to provide opportunities for small practices (and others) to succeed!
- Also responsive to our concerns about the January 1, 2017 start date for reporting
- Details were outlined in the proposed rule...
Pick Your Pace – MACRA/QPP Final Rule for 2017 Reporting

- **Not participating in the Quality Payment Program:**
  If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

- **Test:**
  If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

- **Partial:**
  If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

- **Full:**
  If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

**Participate in the Advanced APM path:**
If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Source: [https://qpp.cms.gov/](https://qpp.cms.gov/)
MIPS Final Rule: Overview of Quality Performance Category

- **Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.
  - Three population measures automatically calculated, but only one used for performance score.

- **Groups using the web interface:** Report 15 quality measures for a full year.

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

- **NOTE:** Key Change from Current Program (PQRS): reduced from 9 measures to up to 6 measures with no domain requirement

- **Year 1 Weight:** 60%
**MIPS Quality Performance Category... ACP Recommendations and CMS’ Response**

<table>
<thead>
<tr>
<th>ACP Recommendations... CMS must:</th>
<th>CMS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take concrete actions to provide clear options for specialties that may be most impacted by too few appropriate measures;</td>
<td>TBD</td>
</tr>
<tr>
<td>Remove the mandate for clinicians to report on at least 1 outcome measure (but give them bonus points if they do) – now only required if doing full reporting;</td>
<td>Somewhat</td>
</tr>
<tr>
<td>Remove the 3 population health measures (and provide optional points for these as well) – 2 are removed from the composite score calculation;</td>
<td>Somewhat</td>
</tr>
<tr>
<td><strong>Make CAHPS for MIPS reporting voluntary;</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>Improve risk adjustment methodology (including incorporating SES);</td>
<td>Somewhat</td>
</tr>
<tr>
<td><strong>Keep data completeness at 50%; and</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>Hold physicians harmless from reporting on topped-out measures</td>
<td>Somewhat</td>
</tr>
</tbody>
</table>

*Selected recommendations included here, complete list with detailed information can be found at: https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf*
MIPS Final Rule: Advancing Care Information

- Fulfill the required (i.e., base) measures for a minimum of 90 days:
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care

- Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

- **For bonus credit, you can:**
  - Report Public Health and Clinical Data Registry Reporting measures
  - Use certified EHR technology to complete certain improvement activities in the improvement activities performance category
  - OR

- You may not need to submit advancing care information if these measures do not apply to you.
# MIPS ACI Performance Category... ACP Recommendations and CMS’ Response

## ACP Recommendations... CMS must:

<table>
<thead>
<tr>
<th>Change the reporting period to 90-days</th>
<th>YES!! – big win for ACP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplify the reporting requirements and scoring!</td>
<td>Somewhat</td>
</tr>
</tbody>
</table>

## ACP proposed a specific alternative scoring approach:

- Removing all yes-required or threshold requirements except for the protecting patient health information attestation
  - NO
- Selecting from a longer list of health IT activities
  - YES

Focus on applying health IT to improve quality and value and not simply the use of the technology – thus, allow for activities and measures to be relevant across more than one performance category (which will also reduce burden). **Bonus points will be offered within ACI for using certified technology to complete an improvement activity**
MIPS Final Rule: Clinical Practice Improvement Activities*

- **Most participants**: Attest that you completed **up to 4** improvement activities for a minimum of 90 days.

- **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area**: Attest that you completed up to 2 activities for a minimum of 90 days.

- **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model**: You will automatically earn full credit.

- **Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model**: Automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard (i.e., are part of an advanced APM, but not a qualifying participant), this assigned score will be full credit. Other APMs will get up to half credit.

- **Year 1 Weight**: 15%

* Now simply called Improvement Activities
# MIPS Improvement Activities Performance Category...

## ACP Recommendations and CMS’ Response

<table>
<thead>
<tr>
<th>ACP Recommendations… CMS must:</th>
<th>CMS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Broaden the PCMH definitions</strong> — include other programs with a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others. <strong>FINAL RULE:</strong> Includes a national program, regional or state program, private payer or other body with at least 500 practices</td>
<td>YES!! — big win for ACP</td>
</tr>
<tr>
<td>Weight all activities the same at 5 points per activity</td>
<td></td>
</tr>
<tr>
<td>▪ Full scoring would be accomplished by attesting to 3 OR being a PCMH, PCMH Specialty Practice, or other APM — <strong>FINAL RULE:</strong> report up to 2 (small, rural, and/or HPSA practices) or 4 activities OR be a PCMH, PCMH specialty practice, or certain APMs;</td>
<td>NO, but improved Somewhat</td>
</tr>
<tr>
<td>Include the following on the list of activities:</td>
<td></td>
</tr>
<tr>
<td>▪ ACP Practice Advisor ®</td>
<td>NO</td>
</tr>
<tr>
<td>▪ ACP’s High-Value Care resources</td>
<td></td>
</tr>
<tr>
<td>▪ Certain defined CME activities (i.e., that involve QI-related work)</td>
<td></td>
</tr>
<tr>
<td>Establish a clear and transparent process for adding new items; and</td>
<td></td>
</tr>
<tr>
<td>Permit practicing clinicians to submit alternative activities for credit and/or consideration for future credit.</td>
<td>NO</td>
</tr>
</tbody>
</table>
MIPS Final Rule: Cost (aka Resource Use)

- No data submission required. Calculated from adjudicated claims.
- Year 1 Weight: 0%
  - This is exactly what ACP asked for... the measures are not yet proven to be reliable and validated in their application to physicians.
Summary of Wins for Small Practices...

- Pick your pace – at a minimum, submit one quality measure or one improvement activity to be protected from a negative adjustment.

- Low volume threshold - changed to be less than $30,000 in Medicare FFS revenue OR less than or equal to 100 Medicare patients – exactly what ACP asked for!

- Funding for technical support - $20 million each year for five years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas.

  - Beginning December 2016, local, experienced organizations will use this funding to help small practices.

- Reduced reporting requirements for improvement activities (1-2 only).

- More options for medical homes to get full credit for improvement activities.
But, when it comes to adding up the composite score...

Source: http://www.macroeducation.org/calvin-hobbes-math/
<table>
<thead>
<tr>
<th>Scoring Approach</th>
<th>CMS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total points for Quality = 60</strong></td>
<td>While CMS did reduce the reporting requirements in most performance categories, the methodology has not been simplified sufficiently and the points available with each measure are not reflective of the value a measure has in the overall composite performance score in most cases.</td>
</tr>
<tr>
<td>• Not #/80 x 50% as proposed</td>
<td></td>
</tr>
<tr>
<td><strong>Total points for Cost/Resource Use = 0</strong></td>
<td></td>
</tr>
<tr>
<td>• Not an average of applicable measures x 10%</td>
<td></td>
</tr>
<tr>
<td><strong>Total points for CPIA = 15</strong></td>
<td></td>
</tr>
<tr>
<td>• Not #/60 x 15%</td>
<td></td>
</tr>
<tr>
<td><strong>Total points for ACI = 25</strong></td>
<td></td>
</tr>
<tr>
<td>• Not #/100 (which could actually be up to 131 points) x 25%</td>
<td></td>
</tr>
</tbody>
</table>
Advanced Alternative Payment Models (APMs)
Advanced Alternative Payment Models (APMs)

Initial definitions from MACRA law, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by Federal Law

As defined by MACRA, advanced APMs must meet the following criteria:

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM either: (1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR (2) is a Medical Home Model expanded under CMMI authority.
Advanced APM Criterion 1: Requires use of CEHRT

- An Advanced APM must require at least 50% of the eligible clinicians in each APM Entity to use CEHRT to document and communicate clinical care. The threshold will increase to 75% after the first year. [change from proposed rule, year 2 will remain 50%]

- For the Shared Savings Program only, the APM may apply a penalty or reward to APM entities based on the degree of CEHRT use among its eligible clinicians.

An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;

**No minimum** number of measures or domain requirements, except that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

**Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:

- Quality measures that are endorsed by a consensus-based entity; or
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.

Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk

An Advanced APM must meet two standards:

- **Financial Risk Standard**: APM Entities must bear risk for monetary losses.
- **Nominal Amount Standard**: The risk APM Entities bear must be of a certain magnitude.

- The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**.
- Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those for other APMs.

FINAL RULE: Changes to “More than Nominal” Risk in Advanced APMs

To qualify as an advanced APM in 2019 and 2020, the entity must be:

1. At risk of losing 8 percent of its own parts A & B revenues when Medicare expenditures are higher than expected
OR

2. At risk of repaying CMS up to 3 percent of total Medicare expenditures

Whichever is lower.

• This is a significant reduction from CMS’ proposed financial risk requirements (which was 4% of total Medicare expenditures).
Medical Home Models:

- Have a **unique financial risk criterion** for becoming an Advanced APM (2.5% of A & B revenues).
- Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category**.

A **Medical Home Model is an APM** that has the following features:

- Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- **Empanelment of each patient** to a primary clinician; and
- **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

How does MACRA Provide Additional Rewards for Participation in Advanced APMs?

Most clinicians who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS improvement activities performance category – these are called MIPS APMs.

Those who participate in the most Advanced APMs may be determined to be qualifying APM participants (“QPs”). As a result, QPs:

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

The 2019 APM Incentive Payment will be based on 2018 2017 services
Independent PFPM Technical Advisory Committee (PTAC)

PFPM = Physician-Focused Payment Model

Goal to encourage new APM options for Medicare clinicians

Submission of model proposals by Stakeholders

Technical Advisory Committee

Secretary comments on CMS website, CMS considers testing proposed models

11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary

For more information on the PTAC, go to: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee
## Advanced APMs: ACP Recommendations and CMS’ Response

<table>
<thead>
<tr>
<th>ACP Recommendations…</th>
<th>CMS must:</th>
<th>CMS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP/Medicare ACOs – Track One MSSP ACOs should qualify; Also consider adding a new track within MSSP to help bridge the transition.</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>Give priority via PTAC for CMMI testing of models involving specialty/subspecialty categories where there are current NO recognized APMs and advanced APM options available.</td>
<td></td>
<td>YES – big WIN for ACP</td>
</tr>
</tbody>
</table>

Reduce the nominal risk amount for advanced APM models

Create a platform to expedite testing for APM recognition of bundled payment and similar episodes of care models

Yes
Advanced APMs...

CMS also outlined a strategy to:

1. Reopen certain APMs for additional application rounds;
2. Amend the design of certain APMs so that they meet the Advanced APM criteria; and
3. Engage in development of new APMs that could be Advanced APMs, potentially including APMs based on recommendations from the PTAC.
# Proposed FINAL Rule (and beyond)
## Advanced APMs

<table>
<thead>
<tr>
<th>Proposed in 2017</th>
<th>New for 2017</th>
<th>New for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Savings Program (Tracks 2 and 3)</strong></td>
<td></td>
<td>Track One Plus (details to be laid out in 2017)</td>
</tr>
<tr>
<td><strong>Next Generation ACO Model</strong></td>
<td></td>
<td>Adding new participants (applications in 2017)</td>
</tr>
<tr>
<td><strong>Comprehensive ESRD Care (CEC) (large dialysis organization)</strong></td>
<td>CEC for non-LDOs</td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Primary Care Plus (CPC+)</strong></td>
<td></td>
<td>Adding more payers &amp; practices (applications in 2017)</td>
</tr>
<tr>
<td><strong>Oncology Care Model (OCM) announced to start in 2018</strong></td>
<td>OCM – 2-sided risk (now starting in 2017)</td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Care for Joint Replacement Payment Models</strong></td>
<td></td>
<td>New voluntary bundled payment model</td>
</tr>
<tr>
<td><strong>Advancing Care Coordination through Episode Payment Models Track 1</strong></td>
<td></td>
<td>Comprehensive Care for Joint Replacement Payment Models</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advancing Care Coordination through Episode Payment Models Track 1</td>
</tr>
</tbody>
</table>

This list may change. CMS will publish a final list before January 1, 2017.
Advanced APM Options in Indiana

1 Next Generation ACO -- Advanced APM in 2017

24 MSSP Track 1 ACOs

- Eligible to move up to Track 1+ for the 2018 performance period
- Reach out to your contact within the ACO to inquire about if they have applied or plan to apply to move up in their track

2 practices in the Oncology Care Model

- Now eligible to be Advanced APMs in 2017 if they opt to move to the two-sided risk track.
ACP Recommendations re: PCMHs as Advanced APMs – Still need to push for this:

- CMS should allow PCMH to qualify as advanced APMs <u>without</u> financial risk, if it meets the criteria laid out in the law
- CMS should allow multiple pathways for PCMHs:
  1. Expedited analysis if Comprehensive Primary Care Initiative and advance planning to expand CPCI
  2. Deeming Process for PCMH programs run by states (e.g., Medicaid programs), non-Medicare payers, and employers
  3. Inclusion of PCMH programs and practices that meet the Medical Home Model Standard for financial risk and nominal amount (beyond CPC+)
Overview of Major Improvements in MACRA Final Rule

- **Pick Your Pace:**
  - To be protected from negative adjustment – report something in just one category (e.g., attest to at least one clinical practice improvement activity)
  - Report on more – over 90 days, could get a positive adjustment
  - Report fully for either 90 days or full year – could get a bigger positive adjustment

- Resource use will be 0% of your composite score – just like ACP asked!

- **MIPS low-volume threshold for small practices** – changed to be less than $30,000 in Medicare FFS revenue OR less than or equal to 100 Medicare patients – exactly what ACP asked for!

- Expanded options for recognized PCMHs to get full credit for CPIA under MIPS

- **New ACO track** – One plus, must be physician-led and will help with transition for track one MSSP programs – will become available in 2018 – ACP win!

- Reduced nominal risk requirements for advanced APMs (that are not medical homes, which already had a different/lower bar)
MACRA Final Rule – Overview of Areas Needing Further Analysis or Improvement

- PCMHs as advanced APMs – no real meaningful expansion of advanced APM options for medical homes; no changes made to nominal risk requirements for PCMHs
- Likely Advancing Care Information – number of activities to meet base score reduced (from 11 to 5), but still all-or-nothing
- Still no virtual groups for small practices
- Overall scoring has not been simplified as we had asked
Recent MACRA Advocacy from ACP

Recent MACRA Advocacy from ACP (cont.)

- Meaningful Use Stage 3 Comments:
  - [www.acponline.org/acp_policy/letters/acp_mu_stage_3_comments_2015.pdf](http://www.acponline.org/acp_policy/letters/acp_mu_stage_3_comments_2015.pdf) (Dec. 14, 2015)
  - [healthaffairs.org/blog/2016/01/14/its-time-to-fix-meaningful-use/](http://healthaffairs.org/blog/2016/01/14/its-time-to-fix-meaningful-use/) (Jan. 14, 2016)


- CMS Measure Development Plan (3/1/16): [www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf](http://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf)
ACP Resources for MACRA – and Value-Based Payment Overall

ACP’s MACRA webpage:  [http://www.acponline.org/macra](http://www.acponline.org/macra)

- Top 10 Things to Do Today to Prepare
- Questions & Answers
- Glossary of Terms
- Recorded webinar and downloadable slides
- 2-Pager Handout
- Links to Tools and Resources
- News – advocacy, etc.

*New* Member Forum for MACRA/QPP:  
[https://www.acponline.org/forums/macra-and-the-quality-payment-program](https://www.acponline.org/forums/macra-and-the-quality-payment-program)

- Questions:  [macra@acponline.org](mailto:macra@acponline.org)
ACP Resources for MACRA – and Value-Based Payment Overall

ACP’s Practice Transformation webpage:
https://www.acponline.org/practice-resources/business-resources/practice-transformation

- ACP’s Support and Alignment Network Grant
- High Value Care Resources
  - HVC Care Coordination Toolkit
- Practice Redesign Support
- Quality Improvement and Registries
- Engaging Patients and Families
ACP Resources for MACRA – and Value-Based Payment Overall

Physician & Practice Timeline (text alerts–acptimeline to 313131) - [http://www.acponline.org/timeline](http://www.acponline.org/timeline)

- Will help you to know key deadlines and prepare for them!

ACP Practice Advisor® - [https://www.practiceadvisor.org/](https://www.practiceadvisor.org/)

- Interactive web tool to assist with quality improvement, practice transformation, and more


- Data from physicians for physicians on EHR selection and usability, including MU certification
ACP Resources for MACRA – and Value-Based Payment Overall

PQRSwizard and ACP Genesis Registry - [https://acp.pqrswizard.com/](https://acp.pqrswizard.com/) and [http://tinyurl.com/genesisregistry](http://tinyurl.com/genesisregistry)

- Registry software option to assist with reporting to CMS on PQRS and/or MU.
- Submit 2016 PQRS data by February 28, 2017
- AND, it will be designed to meet quality, improvement activities, and ACI requirements of MIPS


- Provides current, evidence-based clinical decision support – can help with selecting evidence-based improvement activities

Questions: [macra@acponline.org](mailto:macra@acponline.org)
Centers for Medicare and Medicaid Learning Collaborative

- $785 million
- Prepare 140,000+ clinicians for value-based payments
- ↑ health outcomes for millions of patients
- ↓ unnecessary hospitalization, tests and procedures
- Generate $1-$4 billion in savings
- Build evidence base for practice transformation

Indiana Practice Transformation Networks:
- Great Lakes PTN
- National Rural Accountable Care Consortium
- Vizient PTN

Not recruiting, but check with SAN@acponline.org to get on a wait list.
ACP Support and Alignment Network (SAN)

- Recruit practices into networks (PTNs)
- Enhance and promote ACP Practice Advisor®
- Integrate patient/family partnership
- Support and prepare clinicians
- Build evidence base
ACP Practice Advisor®

- Improve process and structure of care
- Spotlighted practices
- Practice biopsy
- Links to tools based on biopsy results
- CME and MOC

New Modules
- Avoid Unnecessary Testing
- Improve Patient Access
- Improve Care Coordination
- Improve Medication Adherence
- Patient Experience
- Patient Engagement
- Advanced Care Planning
What is the Genesis Registry?

- National, “EHR-Ready”, CMS Qualified Clinical Data Registry (QCDR)
- Supports *continuous* exchange of *standard* EHR data
- Pulls data to populate eMeasures aligned w/ EHR data readiness
- 64 eMeasures 2016 / All NQS Domains/ All MIPS measures
- Benchmarks Across Multiple Specialties
- User friendly and approved feedback reports to drive continuous practice improvement and high quality scores on measures

30,000+ Providers

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21,000,000+ Patients
Genesis Registry Quality Reporting

- Meets reporting requirements for MIPS composite score
  - Quality (60%)
  - Continuous Practice Improvement Activity (CPIA) (15%)
  - Advancing Care Information (ACI) (25%)
- Gap analysis performance results and measure feedback
- Comparisons by practice and specialty to:
  - National benchmarks
  - Peer comparators
Electronic algorithm/practice readiness assessment—practice characteristics, quality measurement experience, quality improvement activities, and readiness

Algorithm does NOT result in a single answer (of MIPS vs APMs)—but rather analyzes the challenges and opportunities with each option—and identifies gap areas (e.g., are you doing care coordination, population management, etc.)

The user identifies their pathway—and is then directed to tailored resources to help them succeed. ACP resources such as Practice Advisor®, Genesis Registry, AmericanEHR, etc.

DEMONSTRATION - https://marvelapp.com/132ie67
While this might be overwhelming, ACP does hope to make your day feel better...

through our advocacy and support efforts.
Contact Information

e-mail: macra@acponline.org

member forum: https://www.acponline.org/forums/macra-and-the-quality-payment-program

webpage: www.acponline.org/macra

ACP can help you navigate upcoming payment changes