“Bending the Cost Curve: The new Alphabet MACRA, MIPS, APMs, ACO, ACA”

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VOCABULARY TEST
ACO
ACCOUNTABLE CARE ORGANIZATION
AFFORDABLE CARE ACT
AMERICAN HEALTH CARE ACT OF 2017
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT
MERIT BASED INCENTIVE PAYMENT SYSTEMS
ADVANCED ALTERNATIVE PAYMENT MODELS
ISSUES FOR MEDICARE

• Growing population
• Aging population
• Growing healthcare costs
• Suboptimal clinical outcomes
  – Errors
  – Reliability
  – Costs
• Sustainable Growth Rate
MARCHING TOWARD VALUE BASED PAYMENTS

- **2005** demonstration projects
- **2007** PQRI (voluntary pay for reporting)
- **2009** Pay for action; penalty for inaction (eRx)
- **2012** Penalty avoidance programs
- **2014** Pay for performance
- **2014** Penalty avoidance
- **Value Based Payment**
**MACRA IMPLEMENTATION TIMELINE**

- **2015**: MACRA Introduced
- **2016**: Final Rule of MACRA Released
- **2017**:
  - MACRA Response Team Activity
    - Charged: March 2016
    - Report Out: May 2017
- **2018**: Performance period
- **2019**: Payment adjustment
- **2019**: Advanced Alternative Payment Models (APM)
- **2019**: Merit Based Incentive Payment System (MIPS)

*June 30th is the deadline to register MIPS reporting method

The timeline for MACRA is not expected to change due to new administration.
Sustainable Growth Rate (SGR) was positioned for a 25% cut in Medicare FFS for 2015.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) introduced a new framework for value-based care.

Merit-Based Incentive Payment System (MIPS) 2019 includes PQRS+MU+VM, which focus on Quality, Resource Use, Practice Improvement, and EHR Use.

Alternative Payment Models (APM) 2019 offer an at-risk business model with ACO, Bundled Payments, and Medical Homes.

**Moving to Population Health**

- **90% by 2018**
- **50% by 2018**
MACRA
Medicare Access and CHIP Reauthorization Act

Healthcare providers must participate in one of two new payment structures beginning in 2019, the first performance year being 2017.

MIPS
(Merit-Based Incentive Payment System)

OR

APM
(Alternative Payment Models)
ALTERNATIVE PAYMENT MODEL

- “Risk sharing”......capitation
- Medicare Shared Savings Program
- Accountable Care Organizations (ACO)
- Bundled Payments
### How Professional Diagnosis Coding Impacts Reimbursement

#### HCC Financial Difference in Coding and Documentation Improvement

<table>
<thead>
<tr>
<th>No Conditions Coded (Demographics only)</th>
<th>Conditions Coded with Poor and Incomplete Specificity</th>
<th>Everything Coded Appropriately (Reviewed for Risk Adjustment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
<td><strong>Factor</strong></td>
<td><strong>Criteria</strong></td>
</tr>
<tr>
<td>82 Year-old Female</td>
<td>.557</td>
<td>82 Year-old Female</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>.179</td>
<td>Medicaid Eligible</td>
</tr>
<tr>
<td>DM (no Manifestations)</td>
<td>.118</td>
<td>DM with Vascular Manifestations</td>
</tr>
<tr>
<td>Vascular Disease (no complication)</td>
<td>.299</td>
<td>Vascular Disease with complication</td>
</tr>
<tr>
<td>No CHF Coded</td>
<td></td>
<td>No CHF Coded</td>
</tr>
<tr>
<td>Patient Total Risk Score</td>
<td>.736</td>
<td>Patient Total RAF</td>
</tr>
<tr>
<td>Per Member Per Month Payment (PMPM)</td>
<td>$454</td>
<td>Per Member Per Month Payment (PMPM)</td>
</tr>
<tr>
<td>Yearly Allotment for Care</td>
<td>$5,420</td>
<td>Yearly Allotment for Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yearly Allotment for Care</td>
</tr>
</tbody>
</table>

#### Real Life: Same Emory Patient, Different Perspectives

**Three Years of PCP Relationship**

- 2/2017
  - Diarrhea (ICD10-CM R19.7, Discharge, Medical)
  - Chronic systolic (congestive) heart failure (ICD10-CM I50.22, Discharge, Medical)

- 7/2016
  - Contusion of rib on right side (ICD10-CM S20.211A, Discharge, Medical)

**One Healthy Start**

- Pelvic ramus fracture
- Subarachnoid Hemorrhage
- Neurogenic bladder
- Hypertensive Heart Disease with heart failure: 0.368
- Chronic AFib: 0.295
- Chronic longterm anticoagulation
- S/P pacemaker
- History of rheumatic heart disease, mitral stenosis, mitral regurg, aortic insufficiency
- Lumbar spinal stenosis, with neurogenic pain
- Senile purpura: 0.252
- OSA
- Osteoporosis
- Insomnia
- Polypharmacy, high risk meds
- Hypothyroidism
- Fall Risk
- Protein Calorie Malnutrition: 0.713

**RAF**

- (or zero in 2015, 2016)
  - 2017: 0.368
  - 2016: 1.383
  - 2015: 1.383

**RAF vs**

- 2017: 1.996
MERIT BASED INCENTIVE PAYMENT: WHO

- Individuals
- **Groups** (mandated for >25 providers)
- Excluded
  - Non-patient facing (<100 encounters)
  - Hospital based (>75% by POS)
  - Low volumes (<100; <$30K)
  - First year Medicare participants
  - ACO
MIPS IS DEFAULT PATH FOR YEAR 1

- CMS expects approximately 85% of all eligible clinicians to be in MIPS for the first performance year.
- All eligible clinicians **must** report something through MIPS in 2017 to avoid a penalty.
- Groups with 25+ providers must report as a group and cannot be segmented within TIN by specialties or other groupings.
- MIPS has been recognized as a potential hardship for small, private practices.
- **Regardless of future plans, the goal for performance year 1 (2017) should be to optimize MIPS performance.**
COST IMPLICATIONS FOR MIPS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>ACI</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>CPIA</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

- Cost component of MIPS increases over time
  - Cost will not factor into reimbursement for measurement year 2017
- Risk scores adjust cost performance
- Part of a bonus or penalty issued by CMS would be due to coding in coming value based payment years
**MERIT BASED INCENTIVE PAYMENT: WHAT**

Weights assigned to each category based on a 1 to 100 point scale

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Note:** These are default weights; the weights can be adjusted in certain circumstances.
QUALITY (60% IN 2017)

- QCDR
- Qualified registry
- EHR
- CMS Web Interface ("GPRO-Web")**
- Administrative Claims

** EHC experience but takes abstractors
**G PRO MEASURES 2017**

- 15 measures total
  - 11 measures scored 2017
  - CMS will calculate 1 additional population measure
- EHC practices score relatively well but
  - Difficulty with non-discrete measures
  - Still abstracting with RNs from notes
  - Believe that acuity is under-coded

<table>
<thead>
<tr>
<th>Metric</th>
<th>MSSP Benchmark (EHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Control by HgbA1C</td>
<td>YES (+) and + on composite</td>
</tr>
<tr>
<td>Diabetic eye exam</td>
<td>YES (-) but + on composite</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Pneumonia vaccine</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Colon cancer screening</td>
<td>YES (+)</td>
</tr>
<tr>
<td>BMI screen and follow-up</td>
<td>YES (-)</td>
</tr>
<tr>
<td>Depression screen and follow-up (PHQ2)</td>
<td>YES (-)</td>
</tr>
<tr>
<td>IVD and antiplatelet medication</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Tobacco use screening and cessation counseling</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Fall Risk screening</td>
<td>YES (+)</td>
</tr>
<tr>
<td>Depression remission at 12 months (PHQ9)</td>
<td>NO</td>
</tr>
<tr>
<td>Statin therapy for prevention and treatment of CVD</td>
<td>NO</td>
</tr>
<tr>
<td>Medication Reconciliation after discharge</td>
<td>NO</td>
</tr>
<tr>
<td>HTN control</td>
<td>NO</td>
</tr>
</tbody>
</table>
COST (0% IN 2017)

- Medicare Spend per Beneficiary
  - 2/3 academic medical centers outperform national average
- Total Per Capita Costs
  - 1/2 academic medical centers outperform national average
- Additional 10 episode specific measures
  - Mastectomy
  - CABG
  - Lens and cataract
# ADVANCING CARE INFORMATION (ACI)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security risk analysis</td>
<td>Y/N</td>
</tr>
<tr>
<td>Provide patient access</td>
<td>N/D</td>
</tr>
<tr>
<td>Electronic prescribing</td>
<td>N/D</td>
</tr>
<tr>
<td>Send summary of care</td>
<td>N/D</td>
</tr>
<tr>
<td>Request summary of care</td>
<td>N/D</td>
</tr>
</tbody>
</table>

## BASE SCORE

### Performance score

- **Electronic patient access**
  - Patient access
  - Patient specific education

- **Patient engagement and coordination of care**
  - View/download/transmit
  - Secure messaging
  - Patient generated data

- **Health Information Exchange**
  - Clinical info reconciliation
  - Care summaries

- **Public health and registry reporting**
  - Immunization registry

---

**MUST SUBMIT ALL**

**Select up to 9 for bonus points**

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# IMPROVEMENT CATEGORIES

<table>
<thead>
<tr>
<th>Expanded access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Patient Engagement</th>
<th>Patient Safety Practice Assessment</th>
<th>APM participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day</td>
<td>Monitors conditions</td>
<td>Communicate test</td>
<td>Establish care for</td>
<td>Surgical check lists</td>
<td>APM activity provides</td>
</tr>
<tr>
<td>After hours</td>
<td>Participate in QDCR</td>
<td>results Exchange information Training for patient</td>
<td>surgical certification</td>
<td>50% score</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remote monitoring</td>
<td>self-management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Telehealth</td>
<td>Shared decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2017 “Pick Your Pace” Options

- No submission
- 4% downward adjustment
- Avoid penalty
- Minimal submission
- Partial year submission
- Neutral to small positive adjustment
- Full year submission
- Possible moderate positive payment adjustment
- Exceptional performer potential
MAXIMIZING MIPS PERFORMANCE

• Accurate risk adjustment
• Infrastructure needs
  • Team based care
  • Population care
  • Optimized EMR
• Reducing unexplained variation
• Performance
  – Outcomes/Cost
  – Publically reported
• Everything efficiently and without waste
STARTING POINTS

TEC

ESA

EMG
2017 PRIORITIES

• There is value in waiting before applying to participate in an APM track
  – Postponing application for an APM allows Emory to focus on risk coding
  – Time to address cost
  – Time to adequately evaluate APM programs as CMS develops them

• Develop plan to address how Emory will assist EHN Private Physicians while under MIPS
“Develop Emory Healthcare’s Population Management Model”
POPULATION MANAGEMENT APPROACH IS DIFFERENT FOR THE DISTINCT POPULATIONS THAT EMORY SERVES

**Emory Patient Population**

- **Local Population Attributed to Emory Healthcare**
  - Includes Emory employees and families, shared savings and capitation contracts, and patients seen by Emory primary care clinicians
  - Emory has a greater ability to manage and coordinate this population's care

- **Patients managed by another health care provider (locally, regionally, and nationally)**
  - The model for this population is still under development
  - Focus should be on how to best coordinate care to return patient to care manager

**No Difference in Emory Clinical Care Delivery**
Future/Ideal Population Management Model to Address Local Attributed Lives – Evolving/In Transition Towards

Population

- High Risk – 5%
  (Multiple Chronic Conditions)
  Represents 30% of Healthcare Spending

- Rising Risk and at Risk – 60%

- Healthy, Preventive, and Episodic Care – 35%

Care Needs
## Enabling Infrastructure

<table>
<thead>
<tr>
<th>Emory Healthcare Provider Network</th>
<th>Community-Based Care</th>
<th>Acute Care</th>
<th>Post-Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Management Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Enabler Support for Providers</strong></td>
<td>Disease Registry</td>
<td>Electronic Connectivity &amp; HIE</td>
<td>TeleHealth</td>
</tr>
<tr>
<td><strong>Data &amp; Analytics Support</strong></td>
<td>Data Normalization</td>
<td>Population Segmentation</td>
<td>Performance Tracking</td>
</tr>
<tr>
<td><strong>Administrative Support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payer Functions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Care Facilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Compensation Model</strong></td>
<td>PCP Compensation Model that Aligns with Panel Management</td>
<td></td>
<td></td>
</tr>
</tbody>
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Care Needs

Enabling Infrastructure

Emory Healthcare Provider Network

Population Management Training

Enabler Support for Providers

Data & Analytics Support

Administrative Support

Payer Functions

Acute Care Facilities

Provider Compensation Model

Enabler Support for Providers

- Disease Registry
- Electronic Connectivity & HIE
- TeleHealth
- Patient Engagement Tools

Data & Analytics Support

- Data Normalization
- Population Segmentation
- Performance Tracking
- Opportunity Identification

Administrative Support

Payer Functions

Acute Care Facilities

Provider Compensation Model

PCP Compensation Model that Aligns with Panel Management
Future/Ideal Population Management Model to Address Local Attributed Lives – Evolving/In Transition Towards

First-Line Care Manager of the Risk Group

Supporting Resources Utilized

High Risk – 5%
(Multiple Chronic Conditions)
Represents 50% of Healthcare Spending

Rising Risk and at Risk – 60%

Healthy, Preventive, and Episodic Care – 35%

Patient-Centered Medical Home

Enabling Infrastructure

Emory Healthcare Provider Network
Population Management Training
Enabler Support for Providers
Data & Analytics Support
Administrative Support
Payer Functions
Acute Care Facilities
Provider Compensation Model

Community-Based Care
Acute Care
Post-Acute Care

Disease Registry
Electronic Connectivity & HIE
TeleHealth
Patient Engagement Tools
Data Normalization
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Opportunity Identification
PCP Compensation Model that Aligns with Panel Management
Future/Ideal Population Management Model to Address Local Attributed Lives – Evolving/In Transition Towards

First-Line Care Manager of the Risk Group

- High Risk – 5%
  (Multiple Chronic Conditions)
  Represents 50% of Healthcare Spending

- Rising Risk and at Risk – 60%

- Healthy, Preventive, and Episodic Care – 35%

Supporting Resources Utilized

- Virtual*, Retail, Urgent Care, Mobile Apps*, Patient Portal, Other Low Intensity Connection Points

Patient-Centered Medical Home

Enabling Infrastructure

- Emory Healthcare Provider Network
- Population Management Training
- Enabler Support for Providers
- Disease Registry
- Electronic Connectivity & HIE
- TeleHealth
- Patient Engagement Tools
- Data & Analytics Support
- Data Normalization
- Population Segmentation
- Performance Tracking
- Opportunity Identification
- Administrative Support
- Payer Functions
- Acute Care Facilities
- PCP Compensation Model that Aligns with Panel Management

*Notes tools that are still under development.
Future/Ideal Population Management Model to Address Local Attributed Lives – Evolving/In Transition Towards

Emory Healthcare Provider Network
Population Management Training
Enabler Support for Providers
Data & Analytics Support
Administrative Support
Payer Functions
Acute Care Facilities
Provider Compensation Model

Community-Based Care
Acute Care
Post-Acute Care

Disease Registry
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Opportunity Identification

High Risk – 5%
(Multiple Chronic Conditions)
Represents 50% of Healthcare Spending

Rising Risk and at Risk – 60%

Healthy, Preventive, and Episodic Care – 35%
PRIVATE PHYSICIANS: WHAT IS THE IMPACT?

Pick Your Pace for Participation for the Transition Year

<table>
<thead>
<tr>
<th>Participate in an Advanced Alternative Payment Model</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some practices may choose to participate in an Advanced Alternative Payment Model in 2017</td>
<td>Test</td>
</tr>
<tr>
<td>• Submit something</td>
<td>Partial Year</td>
</tr>
<tr>
<td>• Submit some data after January 1, 2017</td>
<td>Full Year</td>
</tr>
<tr>
<td>• Neutral payment adjustment</td>
<td>Report for 90-day period after January 1, 2017</td>
</tr>
<tr>
<td>• Neutral or positive payment adjustment</td>
<td>Fully participate starting January 1, 2017</td>
</tr>
<tr>
<td>• Positive payment adjustment</td>
<td></td>
</tr>
</tbody>
</table>

Key Point
• If eligible, they will have to report
• They can also pick a pace for 2017
• Reporting will take resources
• No direct impact to EHC financially under MIPS

NOT REPORTING \( \rightarrow \) 4% PENALTY

Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

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PRIVATE PROVIDERS: WHO ARE ELIGIBLE

• Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

Who is Exempt from MIPS? (No Payment Adjustment)

• Newly-enrolled in Medicare (until next performance period)
• Below the above low-volume threshold
• Significantly participating in Advanced APMs
• Special rules around clinicians practicing in Rural Health Clinics (RHC), Federally Qualified Health Centers, Critical Access Hospitals (CAH) and non-patient facing clinicians
**Emory Healthcare Options to Support Affiliate Private Physicians**

**Affiliated Private Physicians Asking What Level of “Support” Emory Going to Provide to Private Physicians**

<table>
<thead>
<tr>
<th>Support Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>No Support Education Sessions:</td>
</tr>
<tr>
<td>$3,000 – $10,000</td>
<td>Initial Education Sessions:</td>
</tr>
<tr>
<td>$0 – $10,000/yr.</td>
<td>Periodic Education Sessions &amp; CMS Resources:</td>
</tr>
<tr>
<td>$400,000 – $750,000+/yr.</td>
<td>Practice Level Reporting &amp; Performance Assistance:</td>
</tr>
<tr>
<td>$$$</td>
<td>APM</td>
</tr>
</tbody>
</table>

### No Support
- 2 – MACRA Presentations by Premier During 2016 Physician Strategic Planning Meeting
- 3 EHN Private Practice MACRA Group (Chaired by Dr. Cleveland) – Education & Answering Questions
- Premier Consulting Education Session for Private Physicians & Administrators Nov. 2016 & recorded and made available on HLC
- 30 Minute MACRA session by CMS Physician advisor on May 2017 Quality Management Forum

### Initial Education Sessions:
- Internally developed MACRA session updates
- External consultant education sessions
- Active direction to CMS resources for small practices
  - QPP website ([qpp@cms.gov](mailto:qpp@cms.gov))
  - SURS – Alliant GMCF ([OPPsupport@alliantquality.org](mailto:OPPsupport@alliantquality.org))
  - Additional Resources

### Periodic Education Sessions & CMS Resources:
- Himformatics Proposal
  - Phase 1: Assessment Each Practice
  - Phase 2: Plan Action Each Practice
  - Phase 3: Sustain Reporting & Improve Performance Support

### Practice Level Reporting & Performance Assistance:
- APM
- Himformatics Proposal
  - Phase 1: Assessment Each Practice
  - Phase 2: Plan Action Each Practice
  - Phase 3: Sustain Reporting & Improve Performance Support
- Additional Resources
EHN PARTICIPATION - BENEFITS TO PRIVATE PRACTICE PHYSICIANS IN MACRA

- **Quality Metrics:**
  - Of 270+ quality measures some overlap with EHN quality metrics with commercial and/or MA payers

- **Cost:**
  - No cost impact for performance year 2019 (measurement year 2017)
  - Focus on HCC coding of EHN translate to MIPS scoring as well
  - Focus on bending cost trend will translate to MIPS as well

- **Improvement Activities:**
  - Certified Patient Centered Medical Homes: PCMH Academy opened to private PCP practices and currently 3 private practices are enrolled

- **Advancing Care Information:**
  - Eligible clinicians may submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT).
POPULATION MANAGEMENT AND MACRA PERFORMANCE ASSUMPTIONS

• Both MIPS and APM will require a similar population health management strategy

• It is imperative for EHC to figure out how to achieve better outcomes, while lowering overall cost

• EHC’s population management efforts will be based on a single set of guiding principles and infrastructure to avoid wasteful duplication

• Educational processes should be aimed at multiple levels of EHC providers and staff. Outside expertise from a variety of sources should be combined with the current and developing internal expertise
NEXT STEPS

- Significant gaps exist to achieving this future/ideal model, but progress is being made

- PGP Population Management Leadership Group will:
  - Coordinate the various population health efforts across the PGP
  - Define long-term roadmap for the next 5 years to close the gap

- Determine what on-going assistance willing to provide to private physicians in responding to MACRA
Physicians practicing in an Advanced APM who meet certain other criteria will receive a 5% bonus between 2019 and 2024. For 2026 and beyond, clinicians in an Advanced APM will receive a 0.75% increase in the Physician Fee Schedule.

You can choose to participate in several different APMs, including Accountable Care Organizations and demonstrations under the Medicare Health Care Quality Demonstration Program.
Advanced APMs must meet a number of requirements:

1. Participants must accept financial risk for providing coordinated, high-quality care. In order to be considered an Advanced APM, the model must either withhold payments, reduce rates, or require the APM Entity to pay CMS back if the APM Entity’s actual expenditures exceed expected expenditures. The amount of risk that an APM Entity potentially owes to CMS must be at least equal to:
   1. For performance periods 2017 and 2018, 8 percent of the estimated average total Medicare Part A and B revenues of participating APM Entities, or
   2. 3 percent of the expected expenditures for which an APM Entity is responsible under the APM.

2. Payments must be based on quality measures that are evidence-based, reliable, and valid and must include an outcome measure, if applicable.
3. At least 50% of the Advanced APM participants must be required to use certified EHR technology (CEHRT) in the first performance year. This requirement increases to 75 percent in the second performance year.

1. Medical home models developed under the Center for Medicare and Medicaid Innovation (CMMI) authority can also qualify as Advanced APMs. The medical home model financial risk criteria differ somewhat from the criteria applied to other Advanced APMs. While ob-gyns may be able to participate in medical home models in Medicare and Medicaid in the future, at present there are no CMMI medical home models that include ob-gyns.
Physicians practicing within a qualifying APM will receive a 5% bonus between 2019 and 2024. For 2026 and beyond, clinicians will receive a 0.75% increase in the Physician Fee Schedule.

You can choose to participate in several different APMs, including Accountable Care Organizations and demonstrations under the Medicare Health Care Quality Demonstration Program. Advanced APMs must meet a number of additional requirements:
Physicians accept financial risk for providing coordinated, high-quality care. CMS may withhold payments, reduce rates, or require the APM to pay CMS back if the APM’s actual expenditures exceed expected expenditures. The amount of risk must meet these requirements:

• The maximum amount of losses possible under the Advanced APM must be at least 4 percent of the APM spending target.
• Marginal risk — the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM is responsible — must be at least 30 percent.
• Minimum loss rate — the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM Entity has responsibility for losses — must be no greater than 4 percent.
Payments must be based on quality measures that are evidence-based, reliable, and valid; and must include an outcome measure on the MIPS list, if applicable.

At least 50% of the Advanced APM participants must use certified EHR technology (CEHRT) to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

Medical home models developed under the Center for Medicare and Medicaid Innovation (CMMI)authority can also qualify as Advanced APMs. The medical home model financial risk criteria differ somewhat from the criteria applied to other Advanced APMs. While ob-gyns may be able to participate in medical home models in Medicare and Medicaid in the future, at present there are no CMMI medical home models that include ob-gyns.