Making Sense of What’s Next: Value Based P4P Measurement & MACRA

Mike Weiss, DO
September 23, 2016
Making Sense of What’s Next in VBP4P

- Background
- Drivers and Imperatives
- 2016-2021 Measure Set Strategy
- MACRA and the New Landscape
- Now What?
Measure Sets: The Process

- IHA Board
  - Governance Committee
    - Technical Payment Committee
    - Technical Measurement Committee
Criteria for Selecting Measures

- Importance
- Scientific Acceptability
- Feasibility
- Usefulness
- Alignment with Other Initiatives
Criteria for Selecting Measures

- Importance
- Scientific Acceptability
- Feasibility
- Usefulness
- Alignment with Other Initiatives
The Many Stakeholders

- **Patients**
  - Valid, meaningful, informative
- **Physicians/Advanced Practice Providers**
  - Relevance, realistic
- **Health Plans**
  - Quality, satisfaction, cost
- **Physician Organizations**
  - Relevance, ability to influence
- **Federal and State Agencies**
  - Certification requirements
What Does a Doctor Do?

- Internal Medicine Practice, Philadelphia, PA
  - 23.7 Calls per day
  - 16.8 E-mails per day
  - 12.1 Rx Refills per day
  - 19.5 Lab Reviews per day
  - 11.1 X-ray Reviews per day
  - 13.9 Consult Reviews per day

Baron. NEJM, 2010, 362(17) 1632-1636
VBP4P Measure Set Strategy

2012-2015 Strategy
- Relevance
- Team-based Care
- Innovative Measures and Methodologies
- Quality, Resource Use, and Cost
- Measure Suites in Defined Clinical Areas

2016-2021 Strategy
- Increase Alignment
- Target Development Efforts
- Reduce Data Collection Burden and Improve Reporting Timeliness
Key strategies and supporting tactics:

1. **Increase alignment in the VBP4P measure set**
   - Work to align with other commonly used measure sets (QRS, NCQA health plan accreditation, MACRA)
   - Document and communicate where measure set diverges
   - Decrease unwarranted variation in measure specs

2. **Targeted development of the VBP4P measure set**
   - Expand and emphasize Total Cost of Care measurement
   - Evaluate potential of e-Measures
   - Explore feasibility of patient centered measurement

3. **Support less burdensome data collection and more timely reporting**
   - Understand and identify improvements to data sharing processes
   - Support standard mid-year reporting
The MY 2017 VBP4P measure set includes 43 measures recommended for payment and/or public reporting – 27 clinical quality, 2 Meaningful Use e-measures, 6 patient experience (CG-CAHPS), 7 resource use, and 1 total cost of care.

- 38 measures are recommended for payment and 22 of those are publicly reported.

- Of the 27 measures in the clinical quality domain:
  - Nearly 75% of measures are currently NQF endorsed
  - 19 are NCQA Health Plan Accreditation measures
  - 16 are QRS measures (CMS’ Quality Rating System 2016)
  - 8 overlap with the MA stars measure set
MY 2017 Measure Set Changes

**Paid/Publicly Reported**
- Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy
- Statin Therapy for Patients with Diabetes: Received Statin Therapy
- Immunizations for Adolescents will use Combination 2, including HPV Vaccination for Adolescents

**Retirements**
- Appropriate Treatment for Children with URI
- HPV Vaccinations for Female Adolescents & HPV Vaccinations for Male Adolescents

**Testing**
- Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer
How This Prepares Us For The Future
Making Sense of What’s Next: Value Based P4P Measurement & MACRA

Amy Nguyen Howell, MD, MBA, FAAFP
Chief Medical Officer
Objectives

• To briefly review MACRA

• To understand the implications of MACRA on value based P4P measurement

• To share valuable resources to prepare for successful MACRA implementation
• CAPG represents close to 300 physician groups in 41 states, Puerto Rico, and Washington, DC

• The model – financial and clinical accountability
  – Risk-based payment to the physician organization
    • PMPM, shared risk, or bundled payment
  – Physician organization is clinically responsible for patient population, defined in advance
  – Robust internal and external quality reporting infrastructure

• Our mission is to drive the evolution and transformation of health care delivery for our country
Medicare spending will rise from 3.5% to 6% of the economy by 2040.

Medicare and other health spending have substantial effect on debt:
- equaled 35% of GDP at the end of 2007
- Post recession reached 72% of GDP
- Increase in spending of 0.75% the federal debt could be 129% of GDP by 2040

Medicare originally started with 4.6 working people per beneficiary will be reduced to 2.5 workers per beneficiary by 2040.
Hospital Trust Fund

- HI Trust Fund Payroll taxes are not growing as fast as Part A spending; Insolvent by 2030

- Paramount to find different solutions (i.e. ACOs) to reduce hospitalizations for HI Trust solvency without the political consequence of increased payroll taxes

![Graph showing share of GDP in percent from 1966 to 2076.](image)

<table>
<thead>
<tr>
<th>To Maintain HI Trust Fund Solvency</th>
<th>Increase 2.9% Payroll Tax By</th>
<th>Decrease HI Spending By</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 years (2015-2039)</td>
<td>16%</td>
<td>11%</td>
</tr>
<tr>
<td>50 Years (2015-2064)</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>75 years (2015-2089)</td>
<td>23%</td>
<td>15%</td>
</tr>
</tbody>
</table>

*Figure 2. General revenue is paying for growing share of Medicare spending. Retrieved on 7/29/16 from http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf*
In January 2015, the Department of Health and Human Services announced new goals for value-based payments and Alternative Payment Models in Medicare.

**Medicare Fee-for-Service**

**GOAL 1:** Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**30%**

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

**85%**

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

- Set internal goals for HHS
- Invite private sector payers to match or exceed HHS goals

CAPG
The Voice of Accountable Physicians Group
HHS Goals

**2016**
- 30%
- 85%

**2018**
- 50%
- 90%

- **All** Medicare fee-for-service (FFS) payments (Categories 1-4)
- Medicare FFS payments linked to quality and value (Categories 2-4)
- Medicare payments linked to quality and value via APMs (Categories 3-4)
- Medicare payments to those in the most highly “advanced APMs”
### APM Framework: At-A-Glance

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

#### Category 1
- **A**
  - Foundational Payments for Infrastructure & Operations
- **B**
  - Pay for Reporting
- **C**
  - Rewards for Performance
- **D**
  - Rewards and Penalties for Performance

#### Category 2
- **A**
  - APMs with Upside Gainsharing
- **B**
  - APMs with Upside Gainsharing/Downside Risk

#### Category 4
- **A**
  - Condition-Specific Population-Based Payment
- **B**
  - Comprehensive Population-Based Payment
Goals for Payment Reform

Current State

Category 1
Fee for Service
No Link to Quality & Value

Category 2
Fee for Service
Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Future State

Category 1
Fee for Service
No Link to Quality & Value

Category 2
Fee for Service
Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment
What is “MACRA”? 


What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in eligible alternative payment models (APMs)

MACRA replaces the SGR with a more predictable payment method that incentivizes value.
Merit Based Incentive Payment System

✓ MIPS is a new program
  - Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  - Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
MACRA streamlines these programs into MIPS

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare Electronic Health Records (EHR) Incentive Program

Merit-Based Incentive Payment System (MIPS)
MIPS Major Provisions

- Eligibility (participants and non-participants)
- Performance categories & scoring
- Data submission
- Performance period & payment adjustments
Affected clinicians are called “eligible professionals” (EPs) and will participate in MIPS. The types of Medicare Part B health care clinicians affected by MIPS may expand in the first 3 years of implementation.

**Years 1 and 2**
- Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

**Years 3+**
- Secretary may broaden EP group to include others such as:
  - Physical or occupational therapists,
  - Speech-language pathologists,
  - Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists,
  - Dietitians / Nutritional professionals
Eligibility (Non-Participants)

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. Below low patient volume threshold ($<10K in Part B billing AND <100 pts)
3. Certain participants in ELIGIBLE Alternative Payment Models

Note: MIPS does not apply to hospitals or facilities
A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories** on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

**MIPS Composite Performance Score (CPS)**
# Summary of MIPS Performance Categories

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn &quot;full credit&quot; in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Use of certified EHR technology

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice</th>
<th>Use of Certified EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>2020</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>2021</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
</tr>
</tbody>
</table>

% weights for quality and resource use are scheduled to adjust each year until 2021.
# Data Submission Quality & Resource

## Individual Reporting

- Claims
- QCDR
- Qualified Registry
- EHR Vendors
- Administrative Claims (No submission required)

## Group Reporting

- QCDR
- Qualified Registry
- EHR Vendors
- CMS Web Interface (groups of 25 or more)
- CAHPS for MIPS Survey
- Administrative Claims (No submission required)

- Administrative Claims (No submission required)
- Administrative Claims (No submission required)
Data Submission ACI & CPIA

**Individual Reporting**
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor

**Group Reporting**
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- CMS Web Interface (groups of 25 or more)

- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- Administrative Claims (No submission required)
- CMS Web Interface (groups of 25 or more)
Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

**Potential for 3X adjustment**

(A physician who receives +4% adjustment could receive up to +12% in 2019. For exceptional performance, she could earn an additional +10%)

A CPS ≤ 25% of threshold will yield max negative adjustment each year.

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**How much can MIPS adjust payments?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>+4% +5% +7% +9%</td>
</tr>
<tr>
<td>2020</td>
<td>-4% -5% -7% -9%</td>
</tr>
</tbody>
</table>

---

*CPS* stands for the Clinical Performance Score.
## Proposed Rule MIPS Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>July</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Feedback Report (July)</td>
<td>Reporting and Data Collection</td>
<td>2nd Feedback Report (July)</td>
<td>Targeted Review Based on 2017 MIPS Performance</td>
<td>MIPS Adjustments in Effect</td>
<td></td>
</tr>
<tr>
<td>Performance Period (Jan-Dec)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Analysis and Scoring**
There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. Below low patient volume threshold
3. Certain participants in ELIGIBLE Alternative Payment Models
APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**

As defined by MACRA, **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
“Eligible” APMs are the most advanced APMs

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

- Base payment on quality measures comparable to those in MIPS
- Require use of certified EHR technology
- Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority
Note: MACRA does NOT change how any particular APM rewards value. Instead, it creates extra incentives for APM participation.
MACRA provides additional rewards for participating in APMs

### Potential financial rewards

<table>
<thead>
<tr>
<th>Category</th>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments + APM-specific rewards + 5% lump sum bonus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APM-specific rewards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are a qualifying APM participant (QP)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you are a qualifying APM participant (QP):**

- **MIPS adjustments**
- **APM-specific rewards**
- **5% lump sum bonus**
MIPS APMs

• APMs that are not “Advanced APMs” will have to participate in MIPS

• APMs in MIPS have a modified scoring system
  – No Resource Use category

Example: Track One Shared Savings ACO in MIPS
QP Performance Period:
QP Status based on Advanced APM participation

Payment Year:
+5% lump sum given

Incentive Payment Base Period:
Add up payments for QP’s services

2017 2018 2019
Putting It All Together

Fee Schedule

- 2016: +0.5% each year
- 2017: +0.25% each year
- 2018: No change
- 2019: +0.5% each year
- 2020: +0.25% or 0.75% each year
- 2021: No change
- 2022: +0.5% each year
- 2023: +0.25% each year
- 2024: +0.5% each year
- 2025: +0.25% or 0.75% each year
- 2026 & on: +0.25% or 0.75% each year

MIPS

- Max Adjustment (+/-)
  - 2016: +5% bonus (excluded from MIPS)

Participation in Qualifying APM

- 2016: 4
- 2017: 5
- 2018: 7
- 2019: 9 (Max)
- 2020: 9
- 2021: 9
- 2022: 9
- 2023: 9
- 2024: 9
- 2025: 9
- 2026 & on: 9
Proposed Options for MACRA

• **First Option: Test the Quality Payment Program**
  – Submit some data to the Quality Payment Program from after January 1, 2017 to avoid a negative payment adjustment

• **Second Option: Participate for part of the calendar year**
  – Submit for a reduced number of days, later than January 1, 2017 to qualify for a small positive payment adjustment

• **Third Option: Participate for the full calendar year**
  – Submit for a full calendar year, starting on January 1, 2017 to qualify for a modest positive payment adjustment

• **Fourth Option: Participate in an Advanced Alternative Payment Model in 2017**
  – Join an Advanced APM, (e.g., MSSP Track 2 or 3) in 2017 to qualify for a 5% incentive payment in 2019
<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| Quality                | 50%    | • Each measure 1-10 points compared to historical benchmark (if avail.)  
• 0 points for a measure that is not reported  
• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting  
• Measures are averaged to get a score for the category |
| Advancing care information | 25%    | • Base score of 60 points is achieved by reporting at least one use case for each available measure  
• Up to 10 additional performance points available per measure  
• Total cap of 100 percentage points available |
| CPIA                   | 15%    | • Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target |
| Resource Use           | 10%    | • Similar to quality |
### Proposed MIPS Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>0032</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>2372</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>0052</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>0058</td>
<td>Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis</td>
</tr>
</tbody>
</table>
# Cross-Cutting Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>0028</td>
<td>Preventive Care Screening: Tobacco Use: Screening &amp; Cessation*</td>
</tr>
<tr>
<td>0421</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*</td>
</tr>
<tr>
<td>1789/N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>----------</td>
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</tr>
</tbody>
</table>

Table B: Proposed Existing Quality Measures That Are Calculated for 2017 MIPS Performance That Do Not Require Data Submission
<table>
<thead>
<tr>
<th>MIPS ID Number</th>
<th>NQF/PQRS</th>
<th>CMS E-Measure ID</th>
<th>National Quality Strategy Domain</th>
<th>Data submission Method</th>
<th>Measure Type</th>
<th>Measure Title and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>* 0059/001</td>
<td>122 v4</td>
<td>Effective Clinical Care</td>
<td>Claims, Web Interface, Registry, EHR</td>
<td>Intermediate Outcome</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period.</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>§ 0055/117</td>
<td>131 v4</td>
<td>Effective Clinical Care</td>
<td>Claims, Web Interface, Registry, EHR</td>
<td>Process</td>
<td>Diabetes: Eye Exam: Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period.</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>* 0062/119</td>
<td>134 v4</td>
<td>Effective Clinical Care</td>
<td>Registry, EHR</td>
<td>Process</td>
<td>Diabetes: Medical Attention for Nephropathy: The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.</td>
<td>National Committee for Quality Assurance</td>
</tr>
</tbody>
</table>

Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017
### Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017

<table>
<thead>
<tr>
<th>*</th>
<th>§</th>
<th>0421/128</th>
<th>69v4</th>
<th>Community/Population Health</th>
<th>Claims, Web Interface, Registry, EHR</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 – 64 years BMI ≥ 18.5 and &lt; 25 kg/m².</td>
<td>Centers for Medicare &amp; Medicaid Services/Mathematica/Quality Insights of Pennsylvania</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>†</td>
<td>0053/418</td>
<td>N/A</td>
<td>Effective Clinical Care</td>
<td>Claims, Registry</td>
<td>Process</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture: The percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis.</td>
<td>National Committee for Quality Assurance/American Medical Association-Physician Consortium for Performance Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Star</td>
<td>Code</td>
<td>Description</td>
<td>Measure Details</td>
<td></td>
<td></td>
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<tr>
<td>------</td>
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<td>-------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>0097/046</td>
<td>Communication and Care Coordination</td>
<td>Claims, Web Interface, Registry</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication Reconciliation Post- Discharge:** The percentage of discharges from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group:

- Reporting Criteria 1: 18-64 years of age
- Reporting Criteria 2: 65 years and older
- Total Rate: All patients 18 years of age and older.

*Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017*
## Care Coordination Measures

### Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Type</th>
<th>Description</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>! 0326/047</td>
<td>N/A</td>
<td>Communication and Care Coordination</td>
<td>Care Plan: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</td>
<td>National Committee for Quality Assurance / American Medical Association - Physician Consortium for Performance Improvement</td>
</tr>
<tr>
<td>* 0419/130</td>
<td>68, 5</td>
<td>Patient Safety</td>
<td>Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counter, herbsals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.</td>
<td>Centers for Medicare &amp; Medicaid Services / Mathematica / Quality Insights of Pennsylvania</td>
</tr>
</tbody>
</table>

Table A: Proposed Individual Quality Measures Available for MIPS Reporting in 2017
## Measure Alignment

<table>
<thead>
<tr>
<th>MY 2017 Value Based P4P Measures</th>
<th>NCQA Accreditation (2016)</th>
<th>CMS Quality Rating System (2016)</th>
<th>MIPS ! – high priority * – Core Measure</th>
<th>MSSP ACO * – Core Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cause Readmissions</td>
<td>X</td>
<td>X</td>
<td>Hospital All-cause Readmissions</td>
<td>Risk-Standardized, All Condition Readmission</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Monitoring Persistent Medications: ACEI/ARB, Digoxin, Diuretics</td>
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<tr>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>X</td>
<td></td>
<td>X!</td>
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<tr>
<td>Asthma Medication Ratio</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</td>
<td>X</td>
<td>X</td>
<td>X!</td>
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<tr>
<td>Breast Cancer Screening</td>
<td></td>
<td></td>
<td>X!</td>
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<tr>
<td>Cervical Cancer Overscreening</td>
<td></td>
<td></td>
<td>X!</td>
<td></td>
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<tr>
<td>Childhood Immunization Status Combination 10</td>
<td></td>
<td></td>
<td>Combo 3</td>
<td></td>
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<tr>
<td>Chlamydia Screening in Women</td>
<td></td>
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<td>X</td>
<td></td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>X</td>
<td></td>
<td>X*</td>
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<tr>
<td>Controlling High Blood Pressure</td>
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<tr>
<td>Diabetes Care: Blood Pressure Control</td>
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<tr>
<td>Diabetes Care: HbA1c Control &lt;8%</td>
<td>X</td>
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<tr>
<td>Diabetes Care: HbA1c Poor Control &gt;9%</td>
<td>X</td>
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<tr>
<td>Diabetes Care: Nephropathy</td>
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<tr>
<td>Diabetes Care: Two HbA1c Tests</td>
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<tr>
<td>Proportion of Days Covered – Oral Diabetes Medications</td>
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<tr>
<td>Optimal Diabetes Care Combination</td>
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<tr>
<td>Immunizations for Adolescents</td>
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<tr>
<td>Proportion of Days Covered – RAS Antagonists</td>
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<tr>
<td>Proportion of Days Covered – Statins</td>
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<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease</td>
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<tr>
<td>Statin Therapy for Patients with Diabetes</td>
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<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td></td>
<td></td>
<td>X!</td>
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</tr>
</tbody>
</table>

### Additional Notes
- **MIPS**: MIPS is marked as an ! – high priority measure and * – Core Measure.
- **MSSP ACO**: MSSP ACO is marked with an * – Core Measure.
- **Risk-Standardized, All Condition Readmission**: This is marked for hospital all-cause readmissions.
On the Horizon

- MedPAC expects Medicare spending growth to outpace GDP, with total Medicare spending to reach approximately $1 trillion by 2025.
- Physician practice sizes continue to grow, and a greater number are affiliating with health systems and hospitals.
- MedPAC will focus on recommending steps for adjusting the clinician fee schedule to address “misvalued” services in primary care.
- MedPAC is considering how to evaluate initiatives for reducing avoidable hospitalizations of long-stay nursing facility residents.
CAPG Risk Readiness Tool

Hands-on tool to assess your readiness for APMs

Essential, specific checklists for:

• patient safety
• effective clinical care
• patient-centered care and provider communication
• care coordination
• population health

Available for download at www.capg.org/risktool
How to Thrive in Risk-Based Coordinated Care
Oct. 27, 2016, 9:00am–4:00pm  Hyatt Regency O'Hare, Chicago
$100 for CAPG members, $200 for non-CAPG members

Managed Care 101: Utilization Resource Management
Mariella Cummings, Principal, Results Incorporated; Former CEO, Physicians of Southwest Washington

Performance Measurement: HEDIS and STARS and How They Work
Peggy O’Kane, Founder and President, NCQA

The Unique Challenges of Coordinating Hospital and Group in Integrated Delivery Systems
Steve Valentine, Vice President, West Coast Healthcare Management Consulting, Premier

Risk Contracting: What to Know About Stop-Loss Insurance
Kathryn A. Bowen, Area Executive Vice President, Arthur J. Gallagher & Company

Finance Accounting and Solvency Requirements
Matthew M. Mazdyasni, Consultant; Former Chief Administrative and Financial Officer, HealthCare Partners
Our Complimentary Webinars:

The Division of Financial Responsibility (DOFR): Protecting a Physician Organization’s Economic Interests  
**March 17**  9:00am PT / Noon ET  
Stephen Linesch, MBA, SVP, Administration and Development, CAPG

Current State of Affairs at CMS: The New Innovation Center  
**June 30**  11:00am PT / 2:00pm ET  
Hoangmai Pham, MD, MPH, Chief Innovation Officer, Center for Medicare & Medicaid Innovation

How to Improve Patient Satisfaction  
**September 20**  10:00am PT / 1:00pm ET  
Stacey HOUNTAS, Chief Executive Officer, Sharp Rees-Stealy Medical Group

Health Plan Delegation Oversight, Compliance, and Regulations  
**December 2**  9:00am PT / Noon ET  
Grace Diaz, RN, BSN, MBA, CHCQM, Vice President, Accreditation, Credentialing and Clinical Compliance, Government Business Division, Anthem, Inc.
Health Care Payment Learning and Action Network  http://innovationgov.force.com/hcplan

CMS Innovation Center  https://innovation.cms.gov/

MACRA: Medicare Access and CHIP Reauthorization Act of 2015  

Notice of Proposed Rulemaking  

Quality Payment Program  
http://go.cms.gov/qualitypaymentprogram

Transforming Clinical Practice Initiative  
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx
ARE YOU A CAPG MEMBER?
JOIN NOW!

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