

SHIFTS IN PUBLIC POLICY: THE AGS GUIDE FOR GERIATRICS HEALTH CARE PROFESSIONALS

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Leading Change. Improving Care for Older Adults.

Conflict of Interest Statement

There is no conflict of interest to report

Overview of Presentation

- Quick Overview of 2016 Policy Highlights
- Policy Implications for Post-Acute and Long-Term Care
- New Payment Codes
- Medicare Access and CHIP Reauthorization Act (MACRA)
 - MIPS
 - APMS
 - Implications for Geriatrics and Next Steps

AGS Policy Work in 2016

Key Successes

- Older Americans Act reauthorized
- Advance Care Planning codes paid by Medicare
- Passage of the IMPACT Act

What we continue to work on:

- Implementation of MACRA
- Legislation to create clinician educator awards
- Payment for new and innovative codes
- Increased funding for key workforce and research programs

A Briefing on Post-Acute and
Long-Term Care

Kathleen Unroe, MD

Post-Acute Care/ Long-Term Care Policy Considerations

- Protecting Access to Medicare ACT (PAMA)
- IMPACT Act
- Quality Measures

Protecting Access to Medicare Act

- PAMA – passed in 2014 (included “doc fix”)
- Included provisions to promote reduction of avoidable hospital transfers from SNFs through financial incentives and penalties



Protecting Access to Medicare Act

- All SNFs will experience a 2% reduction in their reimbursement from the CMS starting in 2018.
- SNFs will be able to recoup a portion of this by demonstrating an acceptable risk-adjusted readmission ratio and nationally benchmarked rate as calculated by CMS.

Protecting Access to Medicare Act

- October 2016 – CMS will provide SNFs with feedback on their readmission rates.
- October 2017 – these rates will be publicly reported on the Nursing Home Compare website.
- By October 1, 2018 – application of this measure and associated penalties for SNFs will start.

The IMPACT Act

What is the goal? - develop one common data reporting structure across home care, subacute facilities, rehab facilities.

- each site uses redundant but different tools (such as OASIS, MDS) that are not directly comparable for research or utilization management purposes.

The IMPACT Act

Requires standardized patient data:

- Functional status, such as mobility and self care at admission and discharge
- Cognitive function
- Special services and treatments
- Conditions and co-morbidities
- Impairments, e.g. incontinence, hearing loss

Quality Measures

- April 27, 2016 – CMS added 6 new quality measures to Nursing Home Compare.
- The new measures will be incorporated into nursing home star ratings in July 2016.

Quality Measures

- % of short-stay residents successfully discharged to the community
- % of short-stay residents with ED visit
- % of short-stay residents re-hospitalized
- % of short-stay residents with improvements in function
- % of long-stay residents whose ability to move independently worsened
- % of long-stay residents who received an antianxiety or hypnotic medication

Key Takeaways

- Financial penalties will continue to keep focus on developing and implementing best practices to reduce readmissions from SNFs.
- Lots of important detail to watch for in quality metric development – measures need appropriate adjustment for socioeconomic status, morbidity.

Coding and Background on MACRA

Peter Hollmann, MD

New Payment Codes

- AGS working to improve reimbursement for key services not adequately recognized or valued.
- CMS expressed interest in payment for new codes for collaborative care, intense complexity and other under-valued professional work.
- Our work is two-fold –
 - Working directly with CMS
 - Working through the AMA CPT and RUC processes
- **Successes to date:** TCM, CCM, Advanced Care Plan and for CPT 2018 Cognitive Assessment and Care Plan.
- AGS plays a lead role in multi-specialty work (geriatric and other chronic illness specialties)

New Codes We'd Like to See

Codes not presently reimbursed by Medicare that we are currently working towards:

- Complex chronic care management (99487)
- Acute episode non face-to-face care management (2 codes: home, SNF/NF)
- Pharmacist services “incident to” E/M professional (physician, NP, CNS, PA)
- Falls evaluation and care plan

What is MACRA?

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), repealed and replaced Medicare's Sustainable Growth Rate (SGR) formula.
- MACRA changes the way Medicare incorporates quality and cost efficiency measures into physician/clinician payments.
- MACRA incentivizes physicians to participate in alternative payment models.

The Background Which Led to MACRA

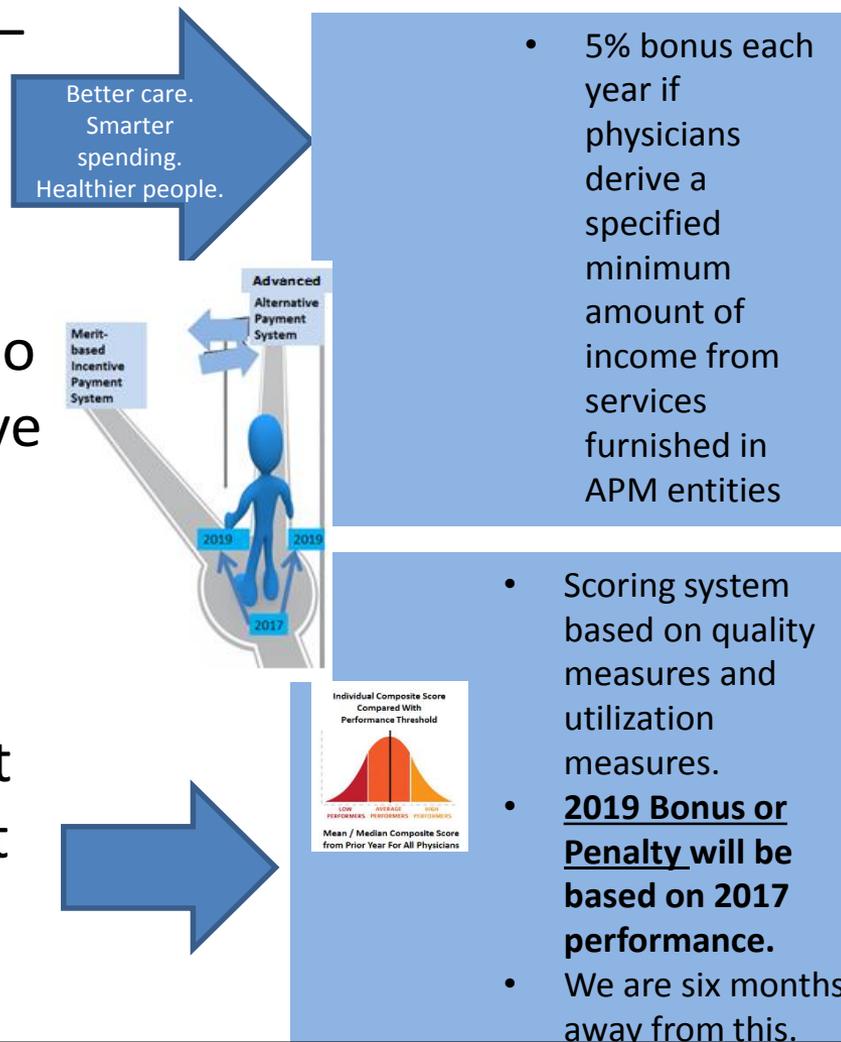
- The year to year SGR approach to review and address the rates for Medicare payments to physicians was not working.
- The anticipated 25% payment cut for physician services was not acceptable.
- The payment to physicians (SGR fix) was an opportunity to link payment to improved quality of care.
- MACRA shifted the focus from “volume to value,” heightening physician incentives to make treatment decisions considering quality and resource use.

The Basics of MACRA and the Key Concepts of Alternate Physician Payment

- MACRA provides two paths in 2019 – both focus on paying for value instead of volume:

1. Incentive payments and higher rate payments for clinicians who participate in eligible Alternative Payment Models (APM's) than for others.

2. Merit-Based Incentive Payment System (MIPS) for clinicians not meeting APM criteria.



*MACRA – Alternative Payment
Pathway*

Paul Rudolf, MD, JD

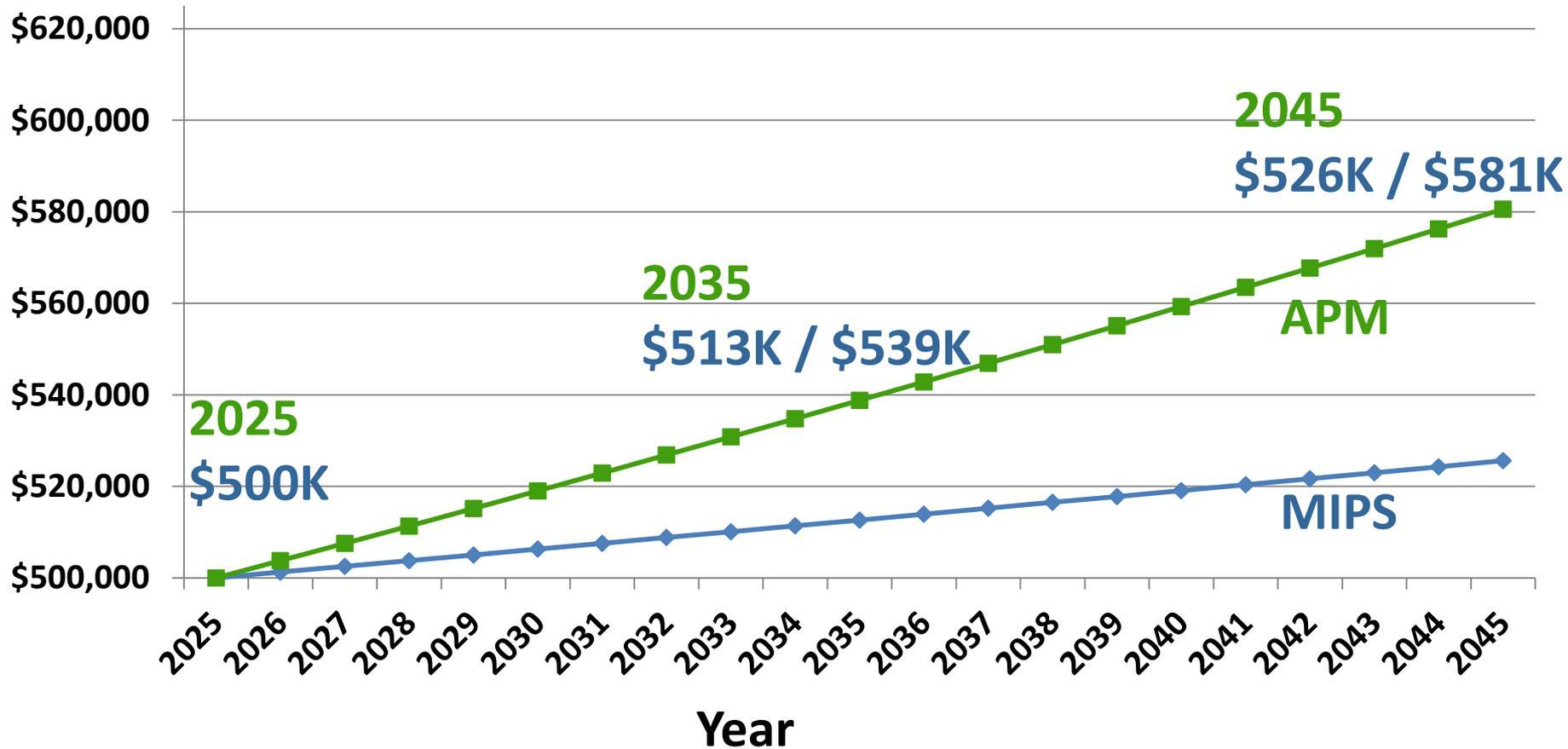
Physicians Face a Dilemma: Will I be Assigned to MIPS or APMs?



- While payments affected beginning in 2019, decisions start even earlier – initial performance period is 2017 for assignment to MIPS or “advanced” APMS
- Participation in APMs not available to all docs
 - CMS estimates only between 31,000 – 90,000 doctors will be assigned to advanced APMs in 2019 which means 90 percent or more of doctors will be in MIPS

Long-Term Advantage of APMs (2025 – 2045)

Annual Medicare Income



Proposed Advanced APM Requirements

- Demonstration required by law
- Thesis being tested
- Entities must have agreement with CMS
- Require clinicians to use certified EHR
- Use quality measures comparable to those in MIPS
- Bear more than nominal risk or be a medical home
- **CMS proposes that whether an APM is an Advanced APM depends solely upon how the APM is designed**
 - Performance within the APM does not affect bonus

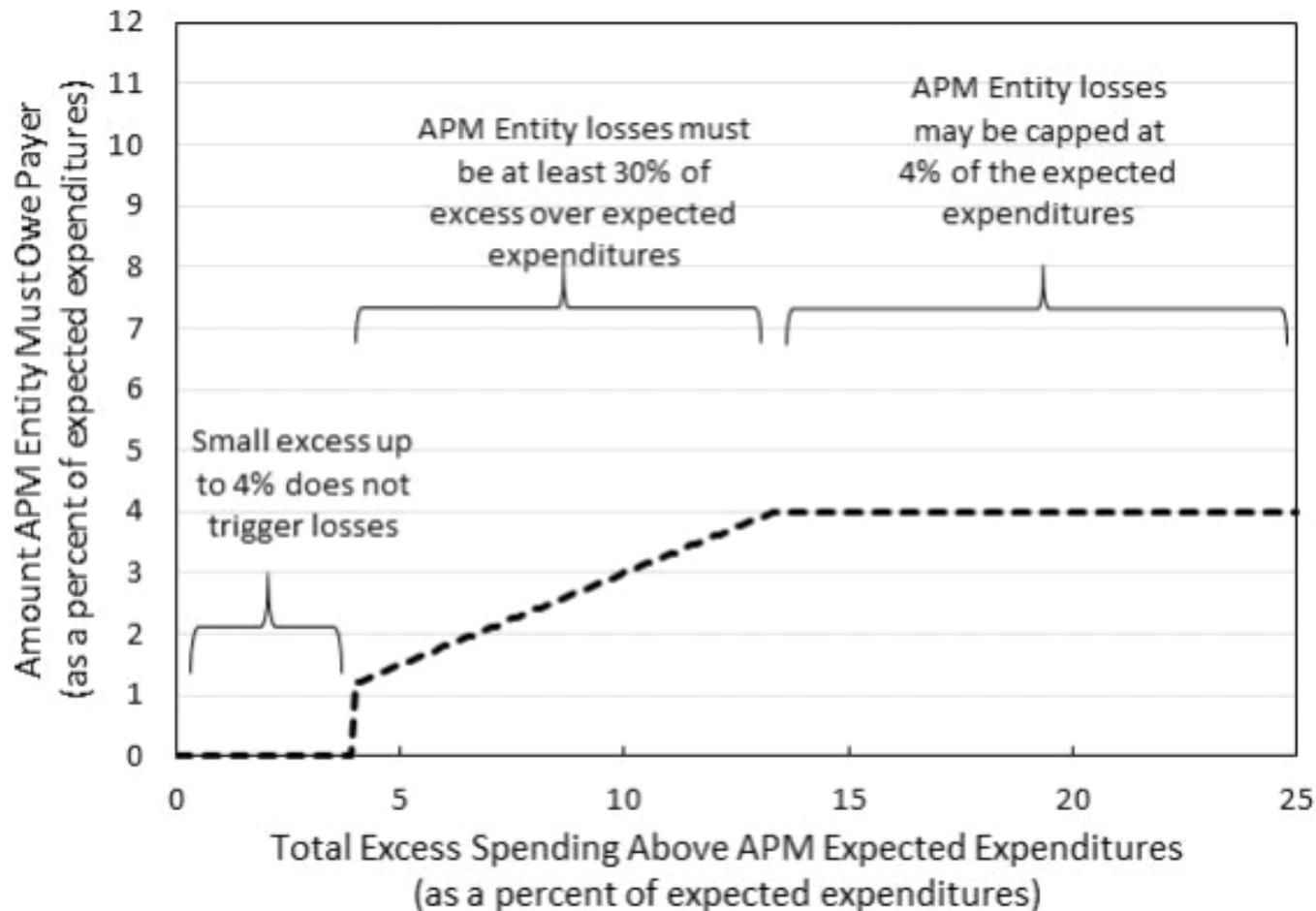
Financial Risk Requirement

- If actual expenditures > expected expenditures, one of the following mechanisms is used to recoup the excess:
 - Withhold payment for services to the APM or the APM entity's eligible clinicians;
 - Reduce payments rates to the APM or the APM entity's eligible clinicians; or
 - Require the APM entity to owe payments to CMS.

Financial Risk Criterion

- APM entity can be allowed small excess in actual expenditures (up to 4%) before recoupment mechanism kicks in
 - Called the “minimum loss ratio” (MLR)
- Above MLR, APM entity must be at risk for at least 30% of excess expenditures
 - Referred to as the “marginal risk”
- Maximum losses for APM entity can be capped but must be at least 4% of expected expenditures
- Financial risk requirements for Medical Homes are different

Financial Risk Example



APMs for the First Performance Year (2017)

- CMS identified 5 current APMs that will be advanced APMs in 2017
 - Tracks 2 and 3 of Medicare Shared Savings Program
 - Next Generation ACO Model
 - Comprehensive ESRD Care
 - Comprehensive Primary Care Plus
 - Oncology Care Model (2018)
- Any additional advanced APMs will be identified when announced

Medical Home Features

Primary care practices or multispecialty practices which include PCPs

- Geriatric medicine is one of the specialties identified as primary care

Empanelment of each patient to a primary clinician

At least four of the following:

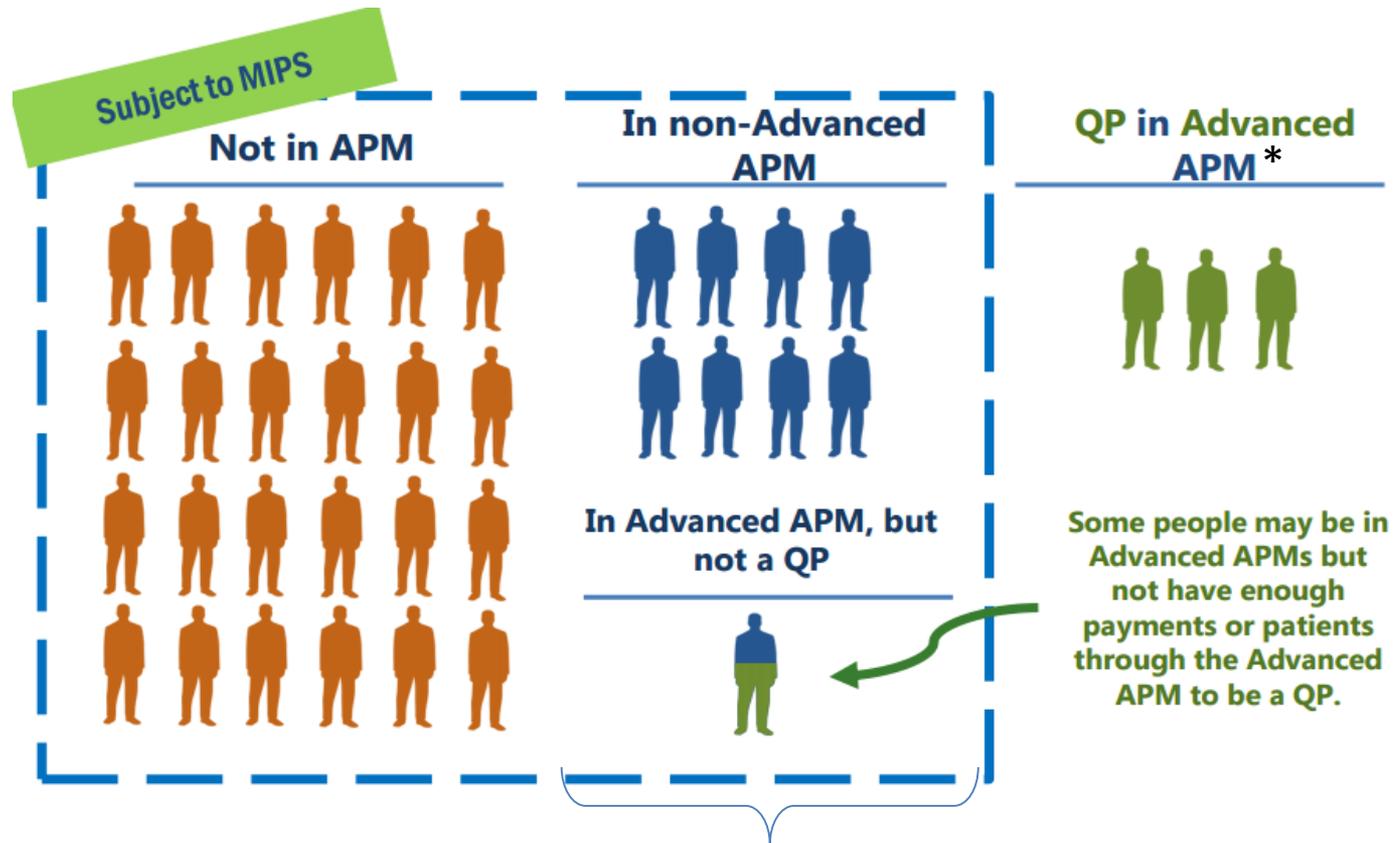
- Planned coordination of chronic and preventive care
- Patient access and continuity of care
- Risk-stratified care management
- Coordination of care across the medical neighborhood
- Patient and caregiver engagement
- Shared decision-making
- Payment arrangements in addition to, or substituting for, FFS payments

After 2017, medical homes subject to size limit (≤ 50 eligible clinicians) and must have increasing amount of revenue at risk

Status of Advanced APMs

Advanced APM Model	Start Date	Notice/ Letter of Intent (LOI) Due	Application Due	Additional Application Cycles Expected?
Medicare Shared Savings Program	1/1/17	5/31/16	7/29/16	Yes
Next Generation ACO	1/1/17	5/20/16	5/25/16	No
Comprehensive ESRD Care	10/1/15	2014	2014	No
Comprehensive Primary Care +	1/1/17	N/A	9/1/16 (Participation is limited to practices in up to 20 geographic regions selected based on reach of participating payers)	Unclear
Oncology Care Model	1/1/18 (two-sided risk track)	2015	2015	No

Where's the Action?



Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Under MIPS, APM participants guaranteed to receive at least a half credit score for Clinical Practice Improvement Activity Category

* Qualifying Participant (QPs)

APM Qualified Participants

- Must be listed as an Advanced APM participant by the Advanced APM in its participation agreement with CMS
 - Advanced APMs must list all participating TINs
 - The TINs include all eligible QPs as identified by their NPIs
 - Listed by December 31 of the QP performance period by the Advanced APM entity
- Advanced APM entity, through collective calculation of all its eligible clinicians, meets the QP payment amount threshold or the QP patient count threshold
 - All eligible QPs in the Advanced APM receive QP status
- QPs with multiple TINs receive QP status across all TINs
 - Bonus applies to all payments from all TINs

Threshold Changes Over Time

- Percent of \$\$\$ paid through Advanced APM or # of patients seen by Advanced APM increases over time
- Harder to reach threshold especially if multiple Advanced APMs in one region
- CMS proposes steps to mitigate this problem
- However, no guarantee of assignment to APM pathway

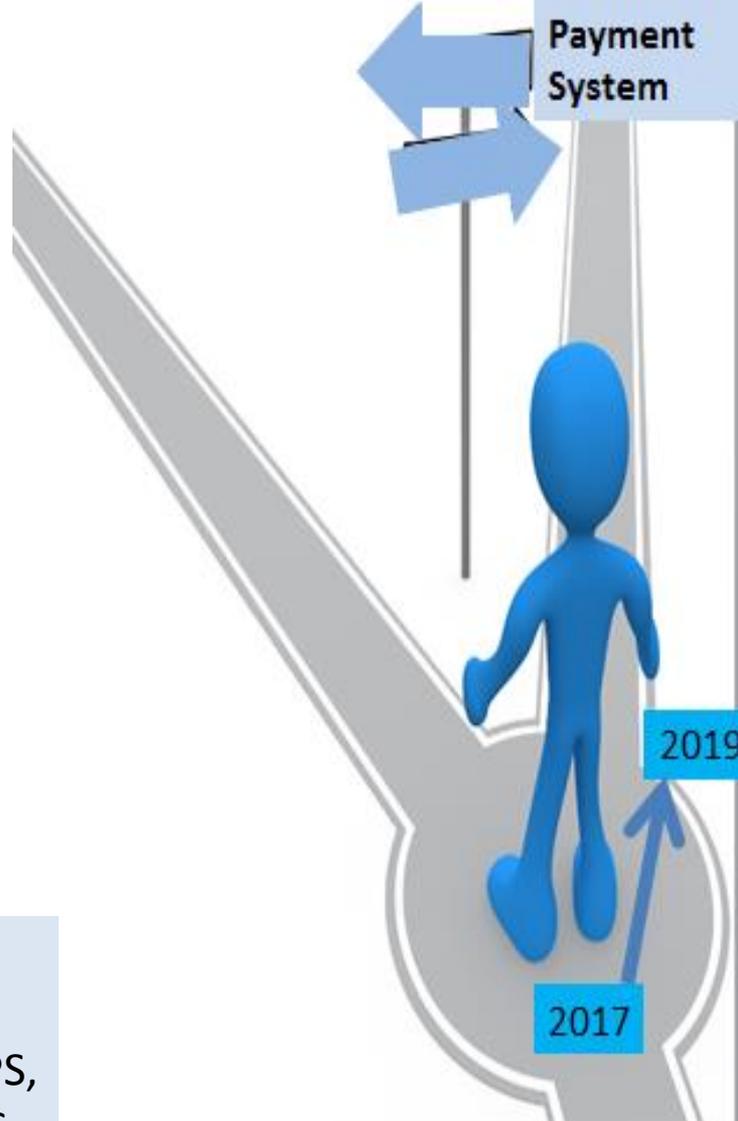
APM Bonus

- Bonus is based on estimated aggregate payments for professional services furnished year prior to the payment year (i.e., 2018 for 2019 bonus) processed through first three months of the bonus year
- Proposal is to pay lump sum bonus to the TIN – not the QP
- If QP participates in multiple qualifying APMs then bonus is paid to each TIN proportionately
- If QP participates in multiple APMs but no individual APM meets threshold for that clinician then QP gets bonus

Non-Advanced APMs

- Clinicians in non-advanced APMs are in MIPS
- CMS calculates performance score differently in order to be consistent with mission of APM
- Quality measures and advancing care information given weight of 0
- Entire score based on clinical practice improvement activities and cost
- Scored in the aggregate – not individually

**Advanced
Alternative
Payment
System**



2019

2017

APM Caveat:

In a given year, one has to be ready to be in MIPS, in case a threshold of \$\$ volume is missed.

Medicare Payment Systems for
Physician Services

MACRA – MIPS

Michael Malone, MD

Merit-based Incentive Payment System

- Generally, all physicians will be eligible to join MIPS.
- Physicians who do not report MIPS measures will receive low performance scores and negative payment updates.



Reference:
Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models
<http://federalregister.gov/a/2016-10032>

Medicare Payment Systems for Physician Services

What is the Merit- Based Incentive Payment System (MIPS)?

- This is a new program in the Medicare fee- for- service payment system.
- This program consolidates 3 existing programs into a single program, and adds a 4th:
 - Meaningful Use.
 - The Physician Quality Reporting System.
 - The Value- Based Payment Modifier

Merit- Based Incentive Payment System (MIPS)

2017 performance data will be used for 2019 payment adjustment.

- CMS proposes to use claims processed up to 90 days after the end of the performance period.

Physicians can participate as individuals or as a group: defined by Taxpayer ID number.

Who is eligible for the Merit- Based Payment System (MIPS)?

MIPS eligible clinicians:

- All physicians.
- Physician assistants.
- Nurse practitioners.
- Clinical nurse specialists.
- Certified registered nurse anesthetists.
- Groups that include such clinicians.

Practitioners excluded from MIPS:

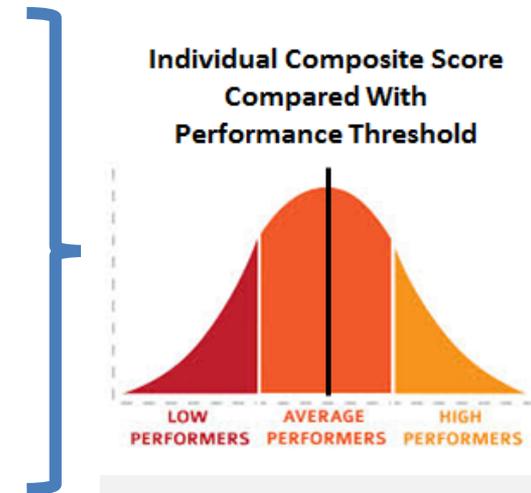
- Newly Medicare-enrolled eligible clinicians.
- Certain participants in Advanced APMs.
- Low- volume threshold clinicians*.



*Less than \$10,000 in Medicare charges and 100 or less Medicare patients in one year.

What is the Merit- Based Incentive Payment System (MIPS)?

- The MIPS will assess individual physician performance in 4 categories and generate a composite score.
 - Clinical Quality: 50%*
 - Resource Use/ Cost: 10%**
 - Meaningful use of certified electronic health record technology: 25%
 - Clinical practice improvement activities: 15%



*year 1 proposed.

** Over time, MIPS has an escalating focus on cost.

The Four Components of MIPS



COST

(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use)



QUALITY

(50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)



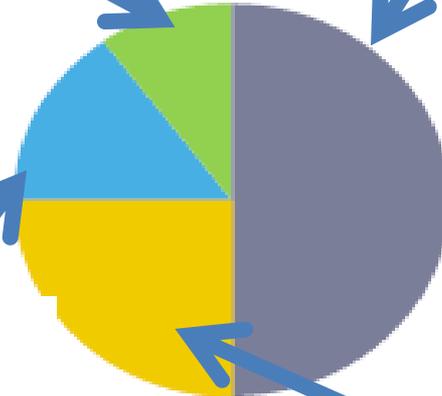
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1)

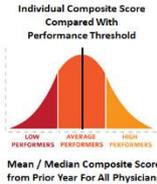


ADVANCING CARE INFORMATION

(25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as “Meaningful Use”)



What is the Merit- Based Incentive Payment System (MIPS)?



- Beginning in 2019, clinicians participating in the MIPS will be eligible for positive or negative Medicare payments.
 - Start at 4% and gradually increase to 9% for 2022.
 - The threshold for these payment adjustments will be the mean composite score for all MIPS- eligible professionals during the previous year.
 - The distribution of payments will follow a bell- shaped curve.
 - 2017 is proposed as the performance period for 2019 payment adjustments.

The Impact of the Proposed Rule

- CMS estimates that overall, most MIPS physicians (54%) will have positive adjustment.
- Hardest hit specialties include chiropractors, dentistry, podiatry, psychiatry, and plastic surgeons.
- Likelihood of positive adjustment increases with practice size:

Practice Size	Eligible Clinicians (ECs)	Percent with Negative Impact
Solo	102,788	87%
2 - 9 ECs	123,695	70%
10 – 24 ECs	81,207	59%
25 – 99 ECs	147,976	45%
100+ ECs	305,676	18%

The Key Themes of How MIPS Works

Individual Composite Score
Compared With
Performance Threshold



Individual physician composite score of 0-100.

- Clinical Quality: 50%
- Resource use: 10%
- Meaningful use of certified electronic health record technology: 25%
- Clinical practice improvement activities: 15%

MIPS
Information
Publicly
Reported
On
Physician
Compare
Web site

Physicians whose score is \geq above the threshold will receive a maximum positive payment adjustment of +4% on each claim for the following year. Additional bonus is possible for exceptional performance.

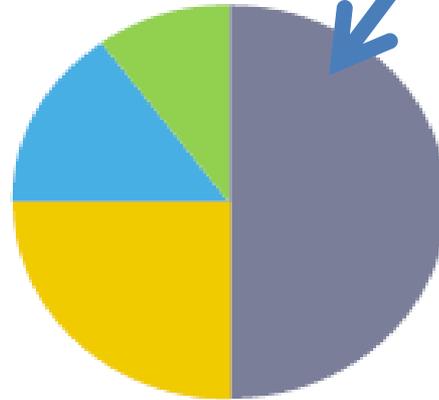
Physicians who score at the threshold composite score will receive no payment adjustment.

Physicians whose composite score is below the threshold will receive a maximum negative adjustment of -4% on each claim for the following year.

Components of MIPS – Quality

Key Points:

- Clinicians would choose to report six measures.
- This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.



QUALITY

(50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)

Quality Measure Category (50%)

Eligible Clinician selects 6 measures

From individual measures or from specialty measure set	Must include 1 cross-cutting measure AND	1 outcome measure (or another high priority measure if outcome is unavailable)	Bonus points available for reporting high priority measures
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High Priority Measures

- Outcome (including intermediate outcome)
- Efficiency
- Appropriate use
- Patient Experience
- Patient Safety
- Care coordination

Cross-Cutting Quality Measures

Title	Description
Care Plan	% of patients aged 65+ with 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.
Documentation of Current Medications in the Medical Record	% of visits for patients aged 18+ for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. List must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
Tobacco Use: Screening and Cessation Intervention	% of patients aged 18+ screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Controlling High Blood Pressure	% of patients aged 18-85 with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

Title	Description
Screening for High Blood Pressure and Follow-Up Documented	% of patients aged 18 + seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
Receipt of Specialist Report	% of patients with referrals, regardless of age, for which the referring provider receives a report from the provider referred to
Tobacco Use and Help with Quitting Among Adolescents	% of adolescents aged 12- 20 with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user
Unhealthy Alcohol Use: Screening & Brief Counseling	% of patients aged 18 + screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Body Mass Index (BMI) Screening and Follow-Up Plan	% of patients aged 18+ 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.
CAHPS for MIPS Clinician/Group Survey	Summary Survey Measures

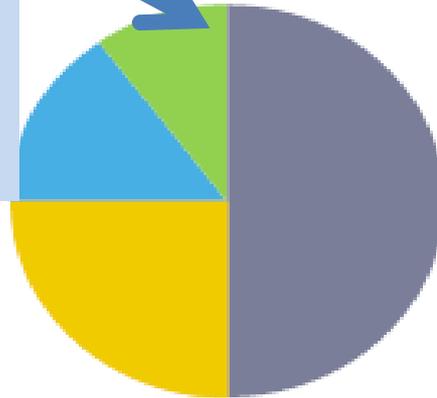
Requirements for MIPS Quality Measures

- Must be established through notice-and-comment rulemaking.
- Prior to inclusion in final rule, must be submitted for publication in applicable specialty-appropriate, peer-reviewed journals with the method for developing and selecting such measure, including clinical and other data supporting such measure.
- Be endorsed by a consensus-based entity or have a focus that is evidence-based.
- **Measures used by a qualified clinical data registry are not subject to these requirements.**

Components of MIPS – Cost



(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use)



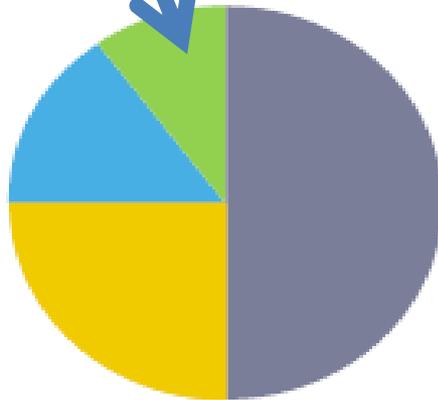
Key Points:

- Score would be based on Medicare claims.
- No reporting requirements for clinicians.
- More than 40 episode-specific measures to account for differences among specialties.

Components of MIPS – Cost



(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use)

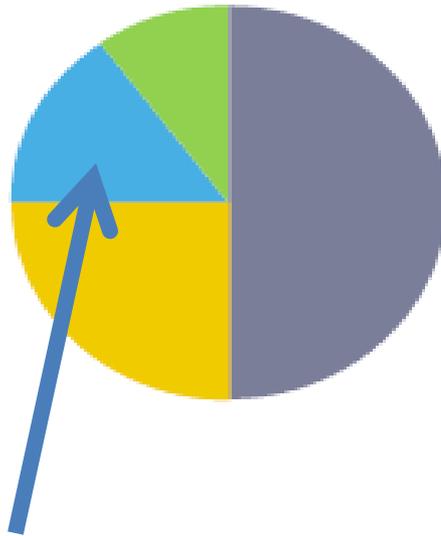


- CMS calculates from claim data.
- No reporting requirement.

Key Points:

- The law requires CMS to measure resources used to treat similar cases across practices:
 - **Episode groups** - based on care provided.
 - **Condition groups** - based on patient's clinical condition.
- **CMS must also create patient relationship codes to allow physicians to classify themselves in relation to the patient:**
 - Primary responsibility for general and ongoing care,
 - Continuing basis during an acute episode, but in a supportive role, etc.

Components of MIPS – Clinical Practice Improvement Activities



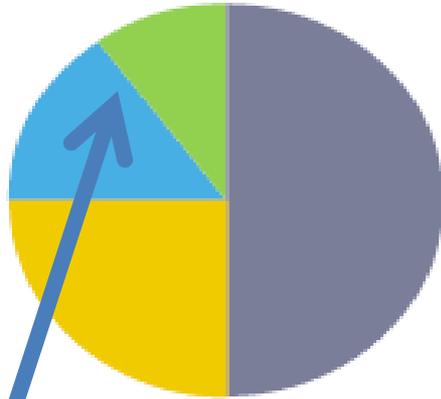
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1)

Key Points:

- Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety.
- Clinicians may select activities that match their practices' goals from a list of more than 90 options.

Components of MIPS – Clinical Practice Improvement Activities



CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1)

Maximum of 60 points from >90 activities.
The physician must select at least one and can get additional credit for more activities.

Expanded Practice Access	Beneficiary Engagement	Achieving Health Equity
Population Management	Patient Safety and Practice Assessment	Emergency Preparedness and Response
Care Coordination	Participation in an APM, including a medical home model	Integrated Behavioral and Mental Health

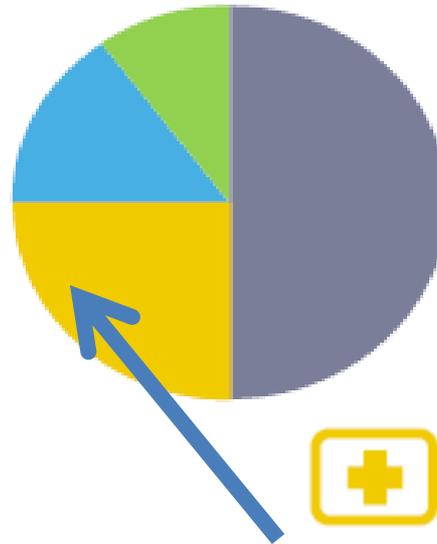
Key Points:

- Highly weighted activities:
 - Patient Centered Medical Home.
 - Activities that support the transformation of clinical practice, or public health priorities.
 - Activities addressing patient experience.
 - Activities to improve timely access.

Components of MIPS – Advancing Care Information

Key Points:

- Clinicians would choose to report customizable measures that reflect how they use EHR technology in their day-to-day practice.
- A particular emphasis is on interoperability and information exchange.
- This category would not require an all-or-nothing EHR measurement or quarterly reporting.



ADVANCING CARE INFORMATION

(25 percent of total score in year 1)

Components of MIPS – Advancing Care Information

**BASE
SCORE**



**PERFORMANCE
SCORE**



**BONUS
POINT**



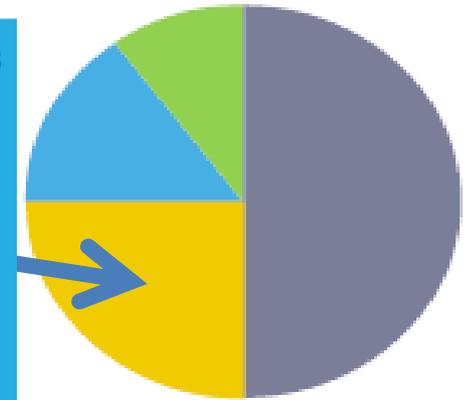
**COMPOSITE
SCORE**

Makes up to
50 points
of the total
**Advancing Care
Information
Performance
Category Score**

Makes up to
80 points
of the total
**Advancing Care
Information
Performance
Category Score**

Up to
1 point
of the total
**Advancing Care
Information
Performance
Category Score**

Earn 100 or more points
and receive
**FULL 25
points**
in the
**Advancing Care
Information
Category** of
MIPS Composite Score



ADVANCING CARE INFORMATION

Components of MIPS – Advancing Care Information

BASE SCORE



PERFORMANCE SCORE



BONUS POINT



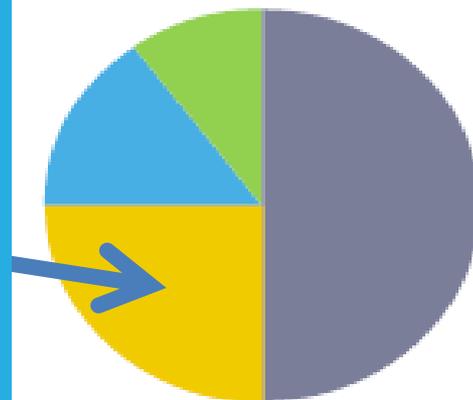
COMPOSITE SCORE

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Category Score

Up to
1 point
of the total
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Information
Performance
Category Score

Earn 100 or more points
and receive
FULL 25 points
in the
Advancing Care
Information
Category of
MIPS Composite Score



Six Measures for Base Score:



Protect Patient Health
Information (yes/no)



Patient Electronic Access
(numerator/denominator)



Coordination of Care
Through Patient Engagement
(numerator/denominator)



Electronic Prescribing
(numerator/denominator)



Health Information Exchange
(numerator/denominator)



Public Health and Clinical Data
Registry Reporting (yes/no)



ADVANCING CARE INFORMATION

Components of MIPS – Advancing Care Information

Public Health Registry*



BASE SCORE



PERFORMANCE SCORE



BONUS POINT



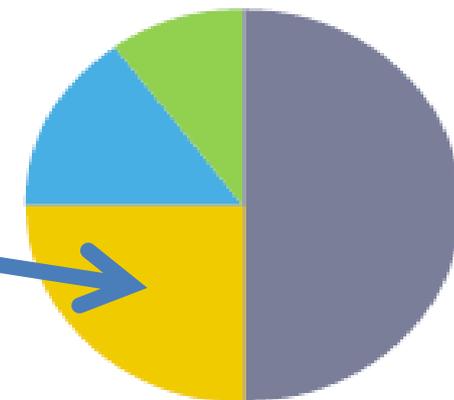
COMPOSITE SCORE

Makes up to **50 points** of the total Advancing Care Information Performance Category Score

Makes up to **80 points** of the total Advancing Care Information Performance Category Score

Up to **1 point** of the total Advancing Care Information Performance Category Score

Earn 100 or more points and receive **FULL 25 points** in the Advancing Care Information Category of MIPS Composite Score



ADVANCING CARE INFORMATION



Patient Electronic Access



Coordination of Care Through Patient Engagement



Health Information Exchange

*Beyond an immunization registry.

The Four Components of MIPS



COST

(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use)



QUALITY

(50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program)



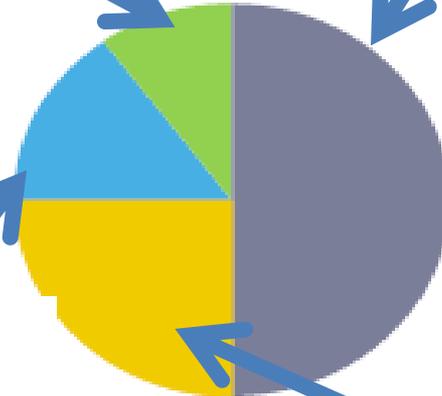
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1)



ADVANCING CARE INFORMATION

(25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use")



How will MACRA affect me?

Am I in an **APM**?

Yes

No

Am I in an **eligible** APM?

Yes

No

Do I have enough **payments or patients through** my eligible APM?

Yes

No

Is this my **first year** in Medicare OR am I below the **low-volume threshold**?

Yes

No

Not subject to **MIPS**

Subject to **MIPS**

Qualifying APM Participant

- 5% lump sum **bonus payment** 2019-2024
- Higher **fee schedule updates** 2026+
- APM-specific **rewards**
- **Excluded** from MIPS

- Subject to **MIPS**
- **Favorable** MIPS scoring
- APM-specific **rewards**

Under MACRA, what's the range of possible FFS updates and incentive payments per year? (Physicians can participate in either MIPS or APM, not both)

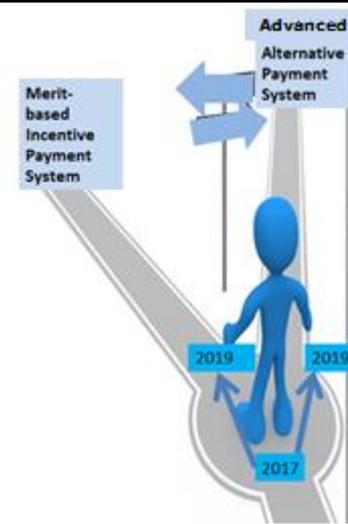
Date	Baseline		MIPS (incentive adjustments), without exceptional performance adjustment*		Baseline, plus/minus MIPS, without exceptional performance adjustment*	MIPS maximum, with exceptional performance adjustment*		APM (FFS bonus only, does not include incentives from own APM pay structure)
4-1-2015	0% instead of 21% SGR cut		N/A		N/A	N/A		N/A
7-1-2015 thru 12-31-2018	0.5% Per year		N/A		N/A	N/A		N/A
2019	0.5%	+/-	4.0%**	=	-3.5% to +4.5%**	14.5%		FFS bonus: +5%
2020	0%	+/-	5.0%**	=	-5.0% to +5.0%**	15%		FFS bonus: +5%
2021	0%	+/-	7.0%**	=	-7.0% to +7.0%**	17%		FFS bonus: +5%
2022, 2023 and 2024	0%	+/-	9.0%**	=	-9.0% to + 9.0%**	19%		FFS bonus +5%
2025	0%	+/-	9.0%**	=	-9.0-% to plus 9.0%**	N/A		0%
2026 and subsequent years	0.25% (for non-APM physicians only)	+/-	9.0%**	=	-8.75% to plus 9.25% **	N/A		0.75%

*Exceptional performance adjustment for those with the highest composite scores, limited to additional adjustment of 10% per year.

**HHS can increase the maximum MIPS *positive* adjustment (not counting the exceptional performance adjustment) to no more than 3x maximum MIPS *incentive adjustment* for that calendar year, if there are sufficient funds available. HHS cannot increase the maximum *negative* MIPS adjustment by more than the amount specified.

The Economics of Medicare's Quality Payment Program

- Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS.
- Advanced Alternative Payment Models in 2019 will have 31,000 to 90,000 qualified providers.
 - \$146 to \$429 million in incentive payments.
- MIPS will distribute payment adjustments to 687,000 to 746,000 eligible clinicians in 2019.
 - \$833 million in positive **and** negative payment adjustments.
 - \$500 million in exceptional performance payments.
- Financial incentives in both programs are proposed to drive quality improvement for Medicare beneficiaries.



Projected Timeline of CMS Activity and Opportunities for AGS to Comment



Episode Groups	Initial Comment Period (3/1/16)		Comments due 8/25/16 on final set of 57 episode groups	CMS releases draft groups (11/16)	Public comment (3/17)			CMS releases operational groups (12/17)
Patient Relationship Codes		CMS releases categories and codes (4/16)	Comments due 8/15/16			CMS releases operational list (4/17)		
MIPS/APM Proposed Rule		Comments due 6/27/16			MIPS Performance Period			

How will Medicare beneficiaries see the changes in the delivery system?

- Their providers are using an EHR during each interaction.
- Their provider is working on strategies to improve care coordination.
- Their providers are reviewing more outcomes measures during their clinical interactions.
- Their practice site is working on more practice improvement efforts:
 - Expanded access/ Portals/ After hours urgent care.
- Practice sites will develop into Patient Centered Medical Homes.
- Efforts to control the costs of care.

What are the key questions geriatricians need to be asking of their group?

- Which direction will we take for our Medicare FFS payments in 2017 and beyond: APM or MIPS?
- What information do we need in order to inform that decision?
- Are you in a group?
- Do we have the infrastructure in place to manage these changes?
- How will these decisions affect my income?

What can you do to prepare for MIPS?

1. Understand how clinical quality will be measured at your site.
2. Define which measures will best meet your patients' needs.
3. Learn more about “episode groups” and “condition groups.”
4. Become involved in qualified:
 - Clinical practice improvement activities.
 - Care delivery improvement activities.
 - Patient- centered medical homes.

The Optimal Role of the AGS

- Prepare and educate our members.
- Continue to monitor and comment on all the rules and regulations.
- Continued guidance from our regulatory experts.
- Comment on how each activity affects our pathways:
 - Making practice desirable.
 - Building our workforce.
 - Improving care.
 - Building the value proposition for geriatrics.
- Advocating for the vulnerable population:
 - Those with multiple co- morbid conditions.
 - Those with cognitive impairment.
 - The frail.

Themes

- The current system of physician payment does not work well for geriatricians.
- We (the AGS) bring(s) a lot of value to the table in the care of older individuals.
- There is a lot we still don't know, but we are committed to getting this right.
- Our patients need and deserve this type of transformation of care.