MACRA, MIPS, and APM’s
Understanding Medicare’s Quality Payment Program (QPP)

John Patrick Yeatts, M.D., M.P.H.
Division of Hospital Medicine
Office of the Vice President for Medical Affairs / CMO
Duke University Health System
None
My Background

Current

Hospitalist at Duke University Hospital
Medical Director within the Office of the Health System VPMA / CMO

Strategic initiatives related to Payer Strategy, Network Development

Education

UNC-Chapel Hill - Economics and Politics, Morehead Scholar
Goldman Sachs International, London - Analyst
Bryn Mawr College – Post Bac Pre Med
UNC Chapel Hill – M.D. / M.P.H.
Duke University Hospital – Internal Medicine / Management & Leadership
Learning Objectives

1. Appreciate the historical context for the current state of health care payment reform
2. Understand the essential elements of the Quality Payment Program (QPP) created by MACRA
3. Identify the potential implications of the QPP on provider practice
Historical Context for Payment Reform
Understanding the Quality Payment Program
Implications and Insights
Deloitte’s 2016 Survey of US Physicians
n = 523 physicians (non-pediatric generalists and specialists)

Figure 1. Physicians are largely unaware of MACRA: Half have never heard of it and another third only recognize it by name.

How familiar are you with MACRA and its requirements?

Total physicians: Percent for each response

- I have never heard of it: 50%
- I recognize the name but am not familiar with its requirements: 32%
- I am somewhat familiar with this law and its requirements: 16%
- I have in-depth knowledge of this law and its requirements: 2%
Deloitte’s 2016 Survey of US Physicians
n = 523 physicians (non-pediatric generalists and specialists)

Figure 2. Independent physicians are somewhat more familiar with MACRA than others

How familiar are you with MACRA and its requirements?

Practice setting: Percent for each response

<table>
<thead>
<tr>
<th></th>
<th>Employed</th>
<th>Independent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have in-depth knowledge of this law and its requirements</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>I am somewhat familiar with this law and its requirements</td>
<td>31%</td>
<td>32%</td>
</tr>
<tr>
<td>I recognize the name but am not familiar with its requirements</td>
<td>59%</td>
<td>45%</td>
</tr>
<tr>
<td>I have never heard of it</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Get ready? For what?
Historical Context for Payment Reform

Understanding the Quality Payment Program

Implications and Insights
The U.S. spends a lot on healthcare

U.S. Healthcare Spending, as a share of GDP

The U.S. spends more than other countries

US spends two-and-a-half times the OECD average

Source: OECD Health Data 2012.
**U.S. health care spending is variable**

### Five Hospital Referral Regions (HRRs) with the Highest and Lowest Actual Per Capita Medicare Spending in 2012

<table>
<thead>
<tr>
<th>Highest per capita HRR</th>
<th>2012 actual per capita spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami, Fla.</td>
<td>$15,357</td>
</tr>
<tr>
<td>Bronx, N.Y.</td>
<td>$14,699</td>
</tr>
<tr>
<td>Manhattan, N.Y.</td>
<td>$13,699</td>
</tr>
<tr>
<td>Los Angeles, Calif.</td>
<td>$13,319</td>
</tr>
<tr>
<td>Chicago, Ill.</td>
<td>$13,059</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lowest per capita HRR</th>
<th>2012 actual per capita spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honolulu, Hawaii</td>
<td>$6,790</td>
</tr>
<tr>
<td>Dubuque, Iowa</td>
<td>$6,716</td>
</tr>
<tr>
<td>Bend, Ore.</td>
<td>$6,667</td>
</tr>
<tr>
<td>Missoula, Mont.</td>
<td>$6,633</td>
</tr>
<tr>
<td>Grand Junction, Colo.</td>
<td>$6,569</td>
</tr>
</tbody>
</table>

**Source**: CMS.gov, "Geographic Variation Public Use Files," updated December 2013.
Relatively poor return on spending

Average Life Expectancy, 1970 & 2011

### Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th>Country</th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Percent of pop. (age 15+) who are daily smokers, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>82.2</td>
<td>3.6</td>
<td>54</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
<td>12.8</td>
<td>14.4</td>
</tr>
<tr>
<td>Canada</td>
<td>81.5&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.8&lt;sup&gt;e&lt;/sup&gt;</td>
<td>56</td>
<td>25.8</td>
<td>14.9</td>
<td>15.2</td>
</tr>
<tr>
<td>Denmark</td>
<td>80.4</td>
<td>3.5</td>
<td>-</td>
<td>14.2</td>
<td>17.0</td>
<td>17.8</td>
</tr>
<tr>
<td>France</td>
<td>82.3</td>
<td>3.6</td>
<td>43</td>
<td>14.5&lt;sup&gt;d&lt;/sup&gt;</td>
<td>24.1&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.7</td>
</tr>
<tr>
<td>Germany</td>
<td>80.9</td>
<td>3.3</td>
<td>49</td>
<td>23.6</td>
<td>20.9</td>
<td>21.1</td>
</tr>
<tr>
<td>Japan</td>
<td>83.4&lt;sup&gt;i&lt;/sup&gt;</td>
<td>2.1</td>
<td>-</td>
<td>3.7</td>
<td>19.3</td>
<td>25.1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.4</td>
<td>3.8</td>
<td>46</td>
<td>11.8</td>
<td>18.5</td>
<td>16.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>81.4</td>
<td>5.2&lt;sup&gt;e&lt;/sup&gt;</td>
<td>37</td>
<td>30.6</td>
<td>15.5</td>
<td>14.2</td>
</tr>
<tr>
<td>Norway</td>
<td>81.8</td>
<td>2.4</td>
<td>43</td>
<td>10.0&lt;sup&gt;d&lt;/sup&gt;</td>
<td>15.0</td>
<td>15.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.0</td>
<td>2.7</td>
<td>42</td>
<td>11.7</td>
<td>10.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82.9</td>
<td>3.9</td>
<td>44</td>
<td>10.3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>20.4&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>81.1</td>
<td>3.8</td>
<td>33</td>
<td>24.9</td>
<td>20.0&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.1</td>
</tr>
<tr>
<td>United States</td>
<td>78.8</td>
<td>6.1&lt;sup&gt;e&lt;/sup&gt;</td>
<td>68</td>
<td>35.3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>13.7</td>
<td>14.1</td>
</tr>
<tr>
<td>OECD median</td>
<td>81.2</td>
<td>3.5</td>
<td>-</td>
<td>28.3</td>
<td>18.9</td>
<td>17.0</td>
</tr>
</tbody>
</table>

---

<sup>a</sup> Source: OECD Health Data 2015.

<sup>b</sup> Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.

<sup>c</sup> DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.

<sup>d</sup> 2012.

<sup>e</sup> 2011.
To Err is Human
Institute of Medicine, 1998

98,000 people die annually in the U.S. from medical error

Medical errors are primarily a system problem

Crossing the Quality Chasm
Institute of Medicine, 2001

Outlines path for improving quality in health care delivery

Health care should be:
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable
## A New Paradigm: Value-Based Care

<table>
<thead>
<tr>
<th>Past: Volume - Based</th>
<th>Future: Value - Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service</td>
<td>Value / Risk based reimbursement</td>
</tr>
<tr>
<td>Care for individuals</td>
<td>Manage populations</td>
</tr>
<tr>
<td>Specialty care focus</td>
<td>Primary care focus</td>
</tr>
</tbody>
</table>

Facilitating this transition is a major undertaking for payers, providers, and patients.
What is “value” in health care? Who gets to define it?

- **Pharmaceuticals:**
  - Should we pay $$$ for drugs to treat XYZ disease?

- **Technology:**
  - Should we start using the newest “ABC” implant or device?

- **Providers**
  - Should we pay “inefficient” or “low quality” hospitals and doctors less?

- **Population health:**
  - Should we pay for population based outcomes?
Brief Historical Context for Payment Reform

Understanding the Quality Payment Program

Implications and Insights
The QPP was formed by MACRA

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

a piece of legislation

Repealed

Medicare Sustainable Growth Rate (SGR)

Created

Medicare Quality Payment Program (QPP)

MIPS: Merit-based Incentive Payment System

APMs: Advanced Practice Models
Medicare Sustainable Growth Rate (1997 – 2015)

• Legislative mechanism to ensure annual increases in Medicare expense did not exceed growth in GDP
• Regulated provider expense and some expenses incidental to provider visits (lab tests, imaging, physician-administered drugs)
• Medicare budget determined annually
• Actual spending compared with budget
  ➢ If spending higher, provider payments decreased the following year
  ➢ If spending lower, provider payments increased the following year
1997 – 2001: Actual expenditures < budgeted, payments increased

2002: Actual expenditures > budgeted, -4.8% payment adjustment

2003 - 2015: Actual expenditures > budgeted, multiple “doc fixes” to avoid further cuts

2015: MACRA repeals the SGR

M.E.I. = Medicare Economic Index (index of the cost to operate a typical medical practice)
MACRA has two tracks

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

- Created
- Medicare Quality Payment Program (QPP)

**MIPS**: Merit-based Incentive Payment System

*Combines CMS’ existing quality reporting programs into one new program*

**APMs**: Advanced Practice Models

*Creates new frameworks for rewarding healthcare providers who provide value-based care*

MACRA applies to payment to PROVIDERS only, not to hospitals or other facilities
How MACRA Helps CMS Accomplish Its Goals

The Merit-based Incentive Payment System (MIPS) links fee-for-service payments to quality and value.

MACRA also provides incentives for participation in Alternative Payment Models (APMs) and bonus payments to “eligible” APMs.

New CMS Goals:

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>85%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

How MACRA Helps CMS Accomplish Its Goals

- **All Medicare fee-for-service (FFS) payments**
- **Medicare FFS payments linked to quality and value**
- **Medicare payments linked to quality and value via APMs**
- **Medicare Payments to those in “eligible” (most highly advanced) APMs under MACRA**
Which track will you belong to?

Am I in an APM?
- Yes
  - Am I in an eligible APM?
    - Yes
      - Do I have enough payments or patients through my eligible APM?
        - Yes
          - Qualifying APM Participant
            - 5% lump sum bonus payment 2019-2024
            - Higher fee schedule updates 2026+
            - APM-specific rewards
            - Excluded from MIPS
        - No
          - Subject to MIPS
            - Subject to MIPS
            - Favorable MIPS scoring
            - APM-specific rewards
    - No
      - Is this my first year in Medicare OR am I below the low-volume threshold?
        - Yes
          - Not subject to MIPS
          - No
            - Subject to MIPS

70,000 – 120,000 providers

500,000 providers
What is “MIPS”?  

The Merit-based Incentive Payment System or “MIPS” combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into a single program.

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

- Quality
- Improvement Activities
- Advancing Care Information
- Resource Use

MIPS Composite Performance Score

Replaces PQRS
New
Replaces Meaningful Use
Replaces the Value-Based Modifier
Weighted Performance Categories Under MIPS

In any given year, the majority (60%) of score is based on Quality and Resource Use (a.k.a., cost)

October 2016 – Final Rule – Resource Use = 0% and Quality = 60%
### Quality
- Requires data submission to CMS
- Most participants will report up to 6 measures
- Groups submitting electronically will report 15 measures

### Advancing Care Information
- Attest completion of measures
- Fulfill a set of 5 required measures
- Submit up to 9 additional measures for extra credit

### Clinical Practice Improvement Activities
- Attest completion of activities
- Most participants attest that they completed at least 4 improvement activities

### Resource Use
- No data submission required
- Calculated from adjudicated claims
- Will NOT impact payment adjustments in 2019

---

You get to select which measures and activities to report

Measures are specialty-specific, but there is overlap of measures between specialties
Examples of Quality Measures (Submit Data)

**Diabetes: Foot Exam**
- The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with monofilament and a pulse exam) during the measurement year.

**Documentation of Signed Opioid Treatment Agreement**
- All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.

**Use of Imaging Studies for Low Back Pain**
- Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**
- The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Approximately 55 measures which map to General / Family Practice
Advancing Care Information (Attest)

Five Required Measures

- **Security Risk Analysis**: Perform 1
- **E-Prescribing**: Transmit at least 1 prescription electronically
- **Provide Patient Access**: Online access for at least 1 patient
- **Send Summary of Care**: Create and send for at least 1 encounter
- **Request/Accept Summary of Care**: Receive and incorporate for at least 1 new patient

Additional Measures (Examples)

- **Secure Messaging**: Send to or receive from at least 1 patient
- **Clinical Data Registry Reporting**: Have an active engagement to send clinical data electronically to a clinical data registry
- **Patient-Generated Health Data**: Incorporate patient-generated data into the HER for at least 1 patient
Examples of Improvement Activities (Attest)

Implementation of fall screening and assessment programs
- Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).

Collection and follow up on patient experience and satisfaction data on beneficiary engagement
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.

Regular training in care coordination
- Implementation of regular care coordination training

Over 90 activities to choose from
• Based on the Composite Performance Score, providers will receive positive, negative or neutral adjustments
• Each provider will receive a quality score between 1 and 100
• Those above average will be eligible for incentives, those below average will receive penalties
### Exceptions to MIPS:

<table>
<thead>
<tr>
<th>Providers in their first year of Medicare participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers below Medicare’s low volume threshold</td>
</tr>
<tr>
<td>• You bill less than or equal to $30,000 in allowable Medicare Part B charges per year OR</td>
</tr>
<tr>
<td>• You see fewer than 100 Medicare beneficiaries per year</td>
</tr>
<tr>
<td>Providers who aren’t one of the following</td>
</tr>
<tr>
<td>• MD</td>
</tr>
<tr>
<td>• PA</td>
</tr>
<tr>
<td>• NP</td>
</tr>
<tr>
<td>• Clinical Nurse Specialists</td>
</tr>
<tr>
<td>• Certified Registered Nurse Anesthetist</td>
</tr>
</tbody>
</table>

**Qualifying Participants (QP’s) in Eligible APMs**
### What is an APM?

<table>
<thead>
<tr>
<th>CMS Innovation Center Model (section 1115A)</th>
<th>MSSP (Medicare Shared Savings Program)</th>
<th>Demonstration under the Health Care Quality Demonstration Project</th>
<th>Demonstration required by Federal Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountable Care Organizations (ACO’s)</td>
<td>• Basically ACO’s</td>
<td>• Gunderson Lutheran Health System</td>
<td>• Unclear</td>
</tr>
<tr>
<td>• Bundles</td>
<td></td>
<td>• Indiana Health Information Exchange (IHIE)</td>
<td></td>
</tr>
<tr>
<td>• Patient Centered Medical home</td>
<td></td>
<td>• Meridian Health System</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• North Carolina Community Care Network (NC-CCN)</td>
<td></td>
</tr>
</tbody>
</table>

All of these are APM’s and constitute **new approaches** to paying providers for value

**Most are not “eligible”** or highly advanced APM’s

Providers in most APM’s will be subject to MIPS but **will receive favorable scoring**
What is an “eligible” or advanced APM?

Eligible APMs are the most advanced APMs that meet the following criteria according to the MACRA law:

- 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) are a medical home model expanded under CMMI authority

Providers who receive payments from an eligible APM are defined as either Qualifying Participants (QP’s) or Partial Qualifying Participants based on meeting either the Payment or Patient Requirement
Determination of **Qualifying Participants** or **Partial Qualifying Participants** status is based on whether or not a percentage of total Part B payments or Patients is derived from an eligible APM.

- **Qualifying participants:**
  - Meet the payment or patient threshold
  - Receive a 5% bonus on their total Part B payments
  - Do not have additional MIPS reporting
  - 0.75% payment adjustment in 2026

- **Partial qualifying participants:**
  - Fall short of revenue threshold
  - Do not receive a 5% bonus on their total Part B payments
  - 0.25% payment adjustment in 2026
  - Can choose whether to report MIPS*
    - Choosing not to report will result in no payment adjustment for that year
    - Decision is made at the entity level and applies to all providers

*Unclear whether this will be a choice or imposed
Both thresholds increase over time.
List of Advanced APM’s

- Comprehensive ESRD Care – Two Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement Payment Model (Track 1)

CMS intends to expand list of Advanced APMs each year
Initial performance period: Jan 1, 2017 – Dec 31, 2017
Can start collecting data anytime, but the more the better
Must submit data to CMS by March 31, 2018
First payment adjustment on Jan 1, 2019
# Choices in 2017: Data Submission

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do not submit any data to CMS</td>
<td>Automatic 4% negative adjustment</td>
<td>2019</td>
</tr>
<tr>
<td>You submit a “minimum” of data to CMS</td>
<td>No downward adjustment, but no increase either</td>
<td>2019</td>
</tr>
<tr>
<td>You submit 90 days of data to CMS</td>
<td>Eligible for a partial fee schedule adjustment</td>
<td>2019</td>
</tr>
<tr>
<td>You submit a full year’s worth of data</td>
<td>Eligible for a full fee schedule adjustment</td>
<td>2019</td>
</tr>
</tbody>
</table>

Fee schedule “adjustment” = positive or negative
Agenda

Historical Background for Payment Reform

Overview of the Quality Payment Program

Implications and Insights
MACRA ≠ ACA

2009
“Obamacare”
Access to Care
Partisan support
Future TBD

2015
“MACRA”
Provider Payment Reform
Bipartisan support
Not going away
MACRA shifts risk to providers

Risk = cost of provider services

Remember the Final Rule: Resource Use = 0% in Year 1

Providers in MIPS will be held increasingly accountable for cost over time
Risk = cost of provider services

MACRA shifts risk to APM providers, too

Providers in APMs better have their model honed by 2025, when the 5% bonuses end.
MIPS may foster competition

• MIPS is **budget neutral**
• This differs from meaningful use, where everyone who hits a threshold gets incentive
• Provider bonuses for some will be offset by penalties for others
• Competition among providers, but not in the traditional sense of just patients in the door
Budget neutrality will mean funds will flow from small group practices to larger group practices.

The burdens of MIPS will be better absorbed by larger practices.
Help for smaller practices

Provision in MACRA to help practices with < 15 clinicians, including those in rural, medically underserved, and health professional shortage areas

CMS names a local organization to:
- Assist practices with quality reporting measures
- Engage practices in continuous quality improvement
- Optimize health IT with practices
- Evaluate a practice’s options for joining an advanced APM

For NC / SC / Georgia / Florida this is Alliant GMCF (Georgia Medicaid), a Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
CMS wants you to become an APM

The 5% bonus in years 2019 – 2024 is meant to entice:

1. Providers to gravitate towards APMs and become QP’s in an eligible (or “advanced”) APM
2. For existing practices to seek alignment with an eligible APM
3. For non-eligible APM’s to become eligible

Just remember:

Eligible APMs bear significant financial risk
MIPS vs APM: Which is better?

For high performing practices, which track makes more sense?

It may be difficult to be a consistent “Top Performer” in MIPS because MIPS is budget neutral (e.g., a zero sum game)

Source: Data compiled based on fee update and performance-based bonuses and penalties under the two incentive programs outlined in the Medicare Access and CHIP Reauthorization Act of 2015.

Note: Advanced APM line excludes contract performance and MIPS excludes the use of a conversion factor that can magnify a MIPS bonus or penalty by as much as three times to ensure budget neutrality.
Outstanding questions

• Will CMS provide practices data-driven feedback in a timely manner to drive performance?
• How easy will it be to move between pathways?
• How will MACRA affect provider transitions and their value in the marketplace?
• How will MACRA affect physician productivity?
HERE. TRY THIS . . . .
Appendix
### Summary: MIPS vs APM

#### MIPS v. APM

<table>
<thead>
<tr>
<th><strong>MIPS</strong></th>
<th><strong>APM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS*</td>
<td>Qualifying Participant (provider meets threshold for “significant” participation in APM)</td>
</tr>
<tr>
<td>Meaningful Use*</td>
<td></td>
</tr>
<tr>
<td>Value-based Modifier*</td>
<td>Partially Qualifying Participant (provider does not meet “significant participation” in APM threshold)</td>
</tr>
<tr>
<td>Merit-Based Incentive Payment System (MIPS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Performance based on quality, resource use, clinical practice improvement activities and meaningful use of EHRs
- Significant reporting burden
- 4-9% of total Part B Spending at risk over time over future FFS rates

- Both options contain some level of “risk”
- Both models require a focus on “efficiency” to succeed
- Participants in an eligible APM qualify for bonus eligibility (which can help offset some risk)
Many Value Based Initiatives

Government
- Value Based Purchasing
- Value based modifier
- Physician Quality Reporting System (PQRS)
- Meaningful Use
- MIPS and APM
- ACOs (Medicare and Medicaid)
- Hospital Readmissions Reduction Program
- Hospital Acquired Conditions Program
- Medicare Advantage: STAR ratings
- Hospice Quality Initiative
- Many others

Private Insurers:
- ACO
- Narrow network
- High performing networks

Providers
- Internal quality benchmarking for QI and compensation
- Transparency of patients satisfaction and outcomes

Payment mechanisms focused on both cost and quality
The U.S. spends a lot of money on healthcare, both in absolute terms and relative to similar countries.

The U.S. derives questionable value from its health care spending.

There is increasing focus on enhancing value in health care.

How one defines value is debatable.