



# An IHS Overview of The Quality Payment Program - MACRA

---

Susy Postal DNP, RN-BC  
Chief Health Informatics Officer

December 16, 2016



# Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

**Important Note:** This presentation was developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

Slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.



# Objectives



1. Identify the background and purpose of the Quality Payment Program (QPP): Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.
2. Review the final rule with comments, addressing framework paths: Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).
3. Discuss payment adjustments and bonuses related to MIPS and APMs.
4. Discuss the impact to clinicians.
5. Identify steps to prepare for the Quality Payment Program within the IHS.



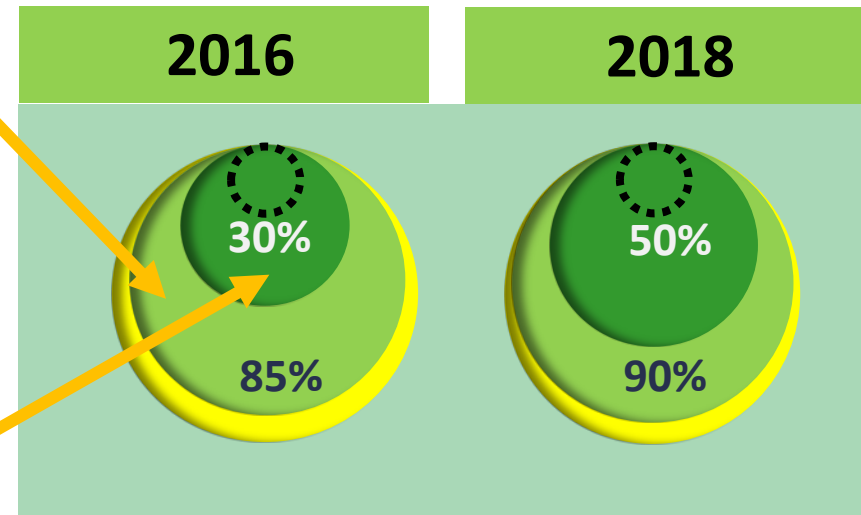
# The Department of Health and Human Services Goals





## Quality Payment Program moves us closer to meeting these goals

The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.

The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced APMs

### New HHS Goals:

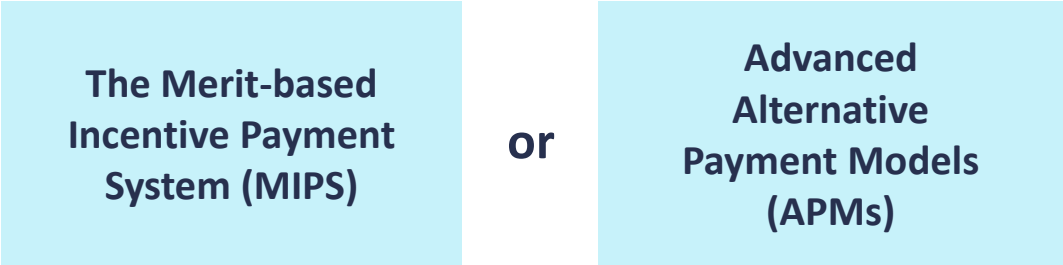


-  All Medicare fee-for-service (FFS) payments (Categories 1-4)
-  Medicare FFS payments **linked to quality and value** (Categories 2-4)
-  Medicare payments linked to quality and value **via APMs** (Categories 3-4)
-  Medicare-Payments to those in the most highly advanced APMs under MACRA



# Quality Payment Program (QPP)

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new **Merit-based Incentive Payment System (MIPS)**
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



- ✓ First step to a fresh start
- ✓ CMS is listening and help is available
- ✓ A better, smarter Medicare for healthier people
- ✓ Pay for what works to create a Medicare that is enduring
- ✓ Health information needs to be open, flexible, and user-centric



# Timeline

April 27, 2016: Notice of Proposed Rule Making

May 2016: Quality Measure Development Plan finalized

June 27, 2016: Public Comments

October 14, 2016: Final Rule

2017: Performance Period (MIPS & APMs)

2019: Payment Year for Quality Payment Program

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Period		Payment Year						



# Public- Submit a Formal Comment



## Submit a Formal Comment

CMS encourages the public to submit comments on the MACRA final rule. Comments are due on **December 19, 2016**, and can be submitted in several ways, including:

- Electronically via <https://www.regulations.gov>
- By regular mail
- By express or overnight mail
- By hand or courier



# Quality Payment Program: Pick Your Pace



- Ready- Begin January 1, 2017
- Not Quite Ready
  - Start anytime between January 1, 2017 - October 2, 2017.
- Send in Performance Data by March 31, 2018







# Clinician Impact

**Which clinicians does  
The Quality Payment Program  
affect?  
(Will it affect me?)**

**Short answer:  
Quality Payment Program  
affects clinicians who participate  
in Medicare Part B.**



# Quality Payment Program: Two Paths



Health care providers to take part in CMS' quality programs in one of two ways:

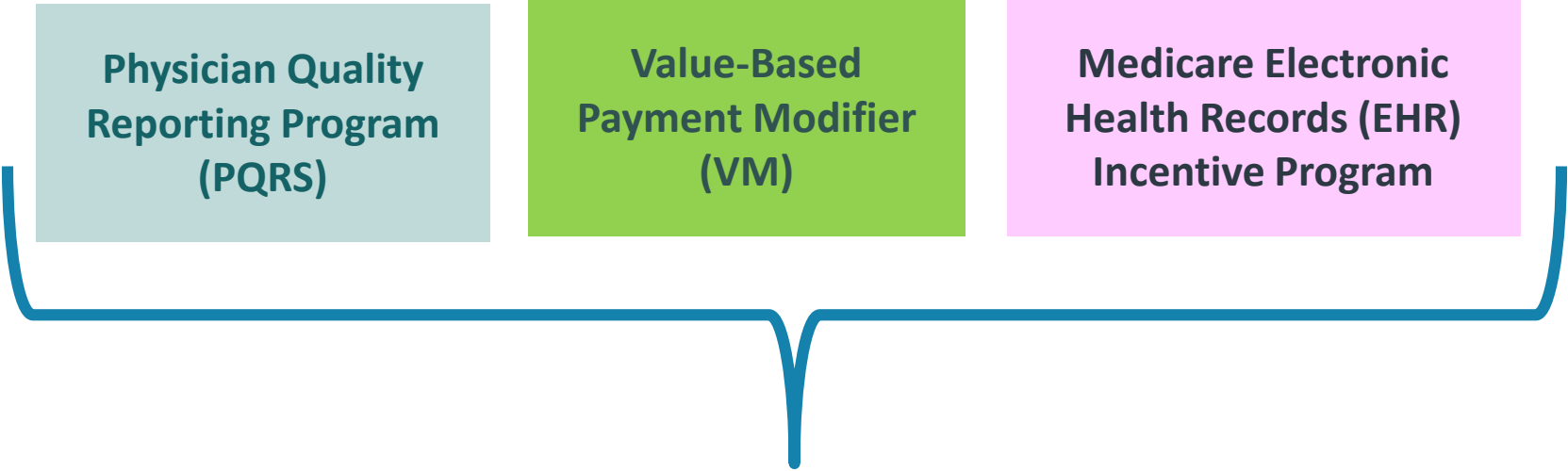
1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (APMs)





# Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:



The **Quality Payment Program/ MACRA** streamlines those programs into **MIPS**

**MIPS**



# MIPS Performance Categories

## How will physicians and practitioners be scored under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:



Quality



Clinical  
practice  
**Improvement  
Activities**



Advancing  
Care  
Information



\*Cost



**FINAL SCORE  
MIPS  
Composite  
Performance  
Score (CPS)**

\*Cost= 0 % weighting the first year



# Year 1 Performance Category Weights for MIPS

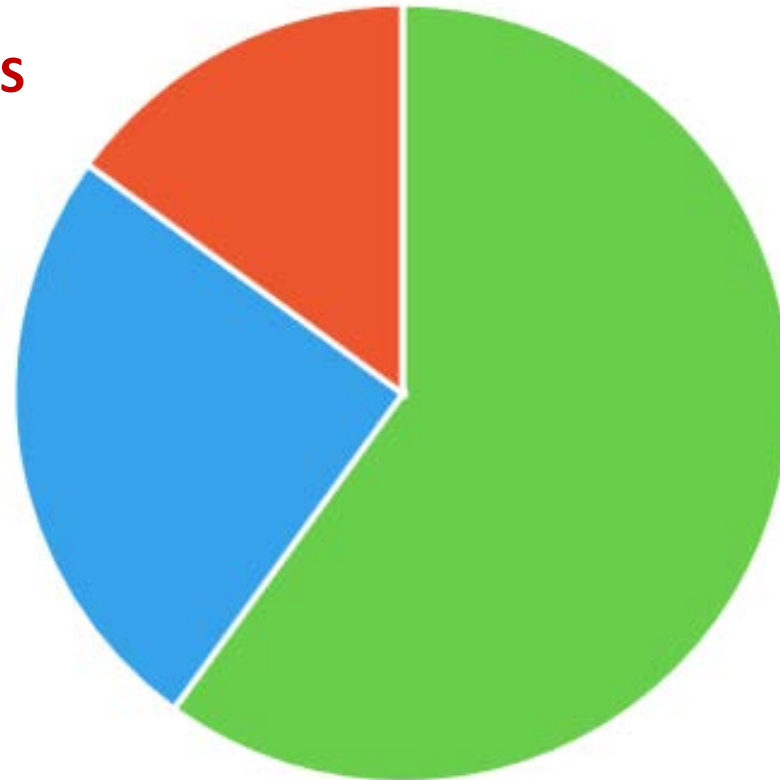


**IMPROVEMENT ACTIVITIES**

**15%**

**ADVANCING CARE  
INFORMATION (ACI)**

**25%**



**QUALITY**

**60%**

**Cost:** Counted starting in 2018



# Quality



Replaces the Physician Quality Reporting System (PQRS).

- ❑ **For full participation, most participants:**
  - Report 6 quality measures (including an outcome measure or high priority measure)
  - Minimum of 90 days.
- ❑ **Groups using the web interface:**
  - Report 15 quality measures
  - Full year
- ❑ **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model:**
  - Report quality measures through your APM.
  - You do not need to do anything additional for MIPS quality.
- ❑ Select Quality Measure Resource <https://qpp.cms.gov/measures/quality>





# Advancing Care Information (ACI)



Fulfill the required measures for a minimum of 90 days:

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send Summary of Care
5. Request/Accept Summary of Care



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

Base score, performance score and bonus score- Ability to earn up to 155 percentage points which will be capped at 100 percent.

Submitting 4 or 5 base score measures – depends on use of 2014 or 2015 Edition



# ACI Objective and Measure Reporting



**TABLE 9: Advancing Care Information Performance Category Scoring Methodology Advancing Care Information Objectives and Measures**

Advancing Care Information Objective	Advancing Care Information Measure*	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
	Electronic Prescribing	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Numerator/Denominator
	Patient-Specific Education	Not Required	Up to 10%	Yes/No Statement
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Yes/No Statement
	Secure Messaging	Not Required	Up to 10%	Yes/No Statement
	Patient-Generated Health Data	Not Required	Up to 10%	Yes/No Statement
Health Information Exchange	Send a Summary of Care	Required	Up to 10%	Numerator/Denominator
	Request/Accept Summary of Care	Required	Up to 10%	Numerator/Denominator
	Clinical Information Reconciliation	Not Required	Up to 10%	Numerator/Denominator
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	Bonus	Yes/No Statement
	Electronic Case Reporting	Not Required	Bonus	Yes/No Statement
	Public Health Registry Reporting	Not Required	Bonus	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	Bonus	Yes/No Statement

Advancing Care Information Objective	Advancing Care Information Measure*	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	e-Prescribing	Required	0	Numerator/Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Numerator/Denominator

Federal Register/ Final Rule with Comment Period P. 768





# Improvement Activities (IA)



- For full participation, most participants:**
  - Attest 4 improvement activities completed
  - Minimum of 90 days.
  
- Groups with fewer than 15 participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area:**
  - Attest up to 2 activities completed
  - Minimum of 90 days.
  
- Participants in certified patient-centered medical homes (PCMH), comparable specialty practices, or an APM designated as a Medical Home Model:**
  - You will automatically **earn full credit**.



# Cost



- No data submission required
- Calculated from adjudicated claims
- For the transition year, the cost performance category will **not** impact payment in 2019
- Starting in 2018, the cost category will be used to determine your payment adjustment.



# Who Will Participate in MIPS?

Medicare Part B clinicians billing **more than \$30,000** a year **AND** providing care for **more than 100 Medicare patients** a year.

Affected clinicians are called **“MIPS eligible clinicians”** and will participate in MIPS.

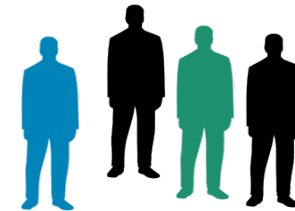
**Years 1 and 2**

**Years 3+**



**Doctors of Medicine, Doctors of Osteopathy, Chiropractors, Dentists, Optometrists, Podiatrists, Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, And Clinical Nurse Specialists**

Secretary may broaden Eligible Clinicians group to include others such as



**Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals**

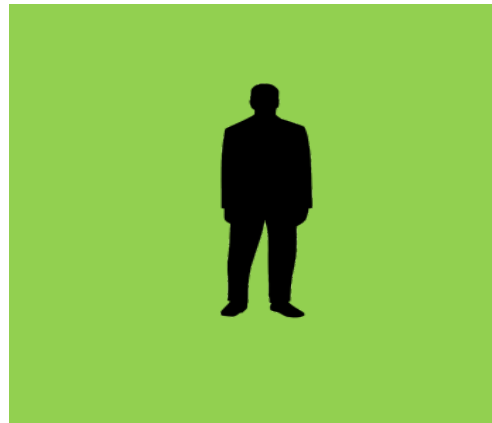


# Who will NOT Participate in MIPS?

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



**FIRST** year of Medicare Part B participation



Below **low patient volume** threshold



**Certain** participants in **ADVANCED** Alternative Payment Models

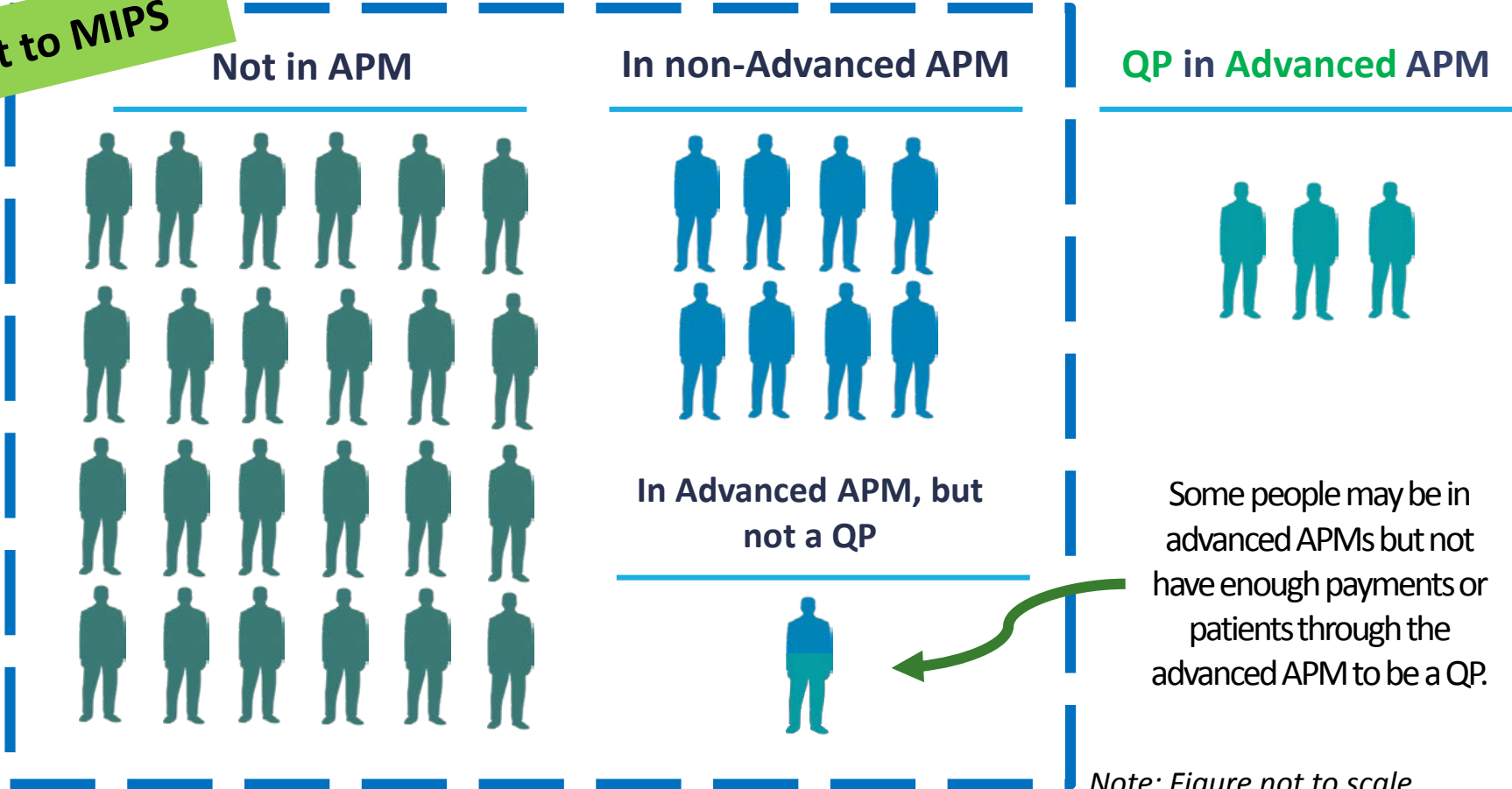
*Medicare billing charges less than or equal to \$30,000 (NOT ~~10,000~~)  
**OR and** provides care for 100 or fewer Medicare patients in one year*

Note: MIPS **does not** apply to hospitals or facilities (Part A)



# Note: Most clinicians will be subject to MIPS.

**Subject to MIPS**



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

*Note: Figure not to scale.*



# Easier Access for Small Practices



Small practices will be able to successfully partake in the Quality Payment Program

- ❑ Reducing the time and cost to participate
- ❑ Providing a transition to help participate through Pick Your Pace
- ❑ Increasing opportunities to participate in Advanced APMs
- ❑ Conducting Technical Support and outreach to small practices through the forthcoming Quality Payment Program Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.
- ❑ CMS Fact Sheet Where do I go for Help with the Quality Payment Program [https://qpp.cms.gov/docs/QPP Where to Go for Help.pdf](https://qpp.cms.gov/docs/QPP%20Where%20to%20Go%20for%20Help.pdf)

Quality Payment Program Fact Sheet • October 14, 2016

Where do I go for help with the Quality Payment Program?

There is a new Quality Payment Program [website](#), which will explain the new program and help clinicians easily identify the measures and activities most meaningful to their practice or specialty. This tool allows interested clinicians and practice managers to browse and explore the program options that best fit their practice.

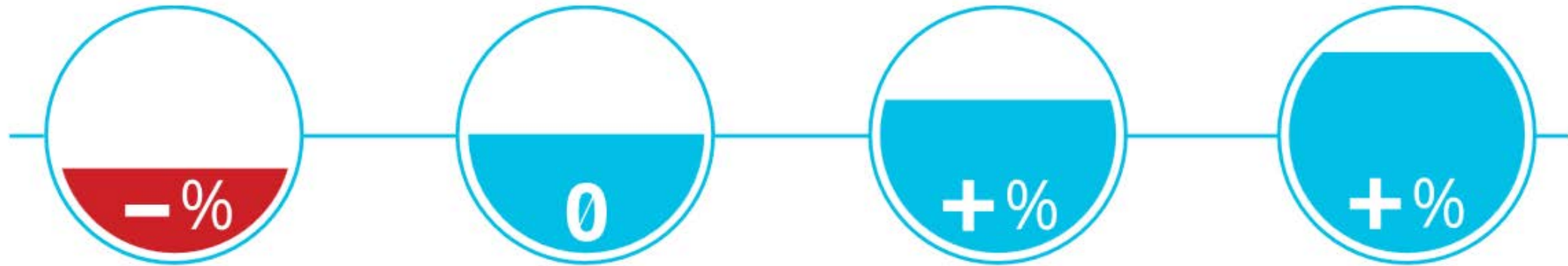
CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

- TCPI** Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click [here](#) to find help in your area.
- QIN-QIOs** Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found [here](#).
- APM Learning Systems** If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.

CMS



# MIPS: Pick Your Pace



Don't Participate

Submit Something

Submit a Partial Year

Submit a Full Year

Positive adjustments are based on performance data on the performance information submitted.  
**Not the amount of information or the length of times submitted.**



# Final Rule MIPS Data Submission Options Quality and Cost

Individual Reporting



Group Reporting



Quality



Cost

<ul style="list-style-type: none"> <li>✓ Claims</li> <li>✓ Qualified Clinical Data Registry (QCDR)</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendors</li> </ul>	<ul style="list-style-type: none"> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendors</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> <li>✓ CAHPS for MIPS Survey</li> <li>✓ Administrative Claims (No submission required)</li> </ul>
No reporting required	No reporting required





# Final Rule MIPS Data Submission Options ACI and IA



Individual Reporting



Group Reporting



**Advancing  
care  
information**



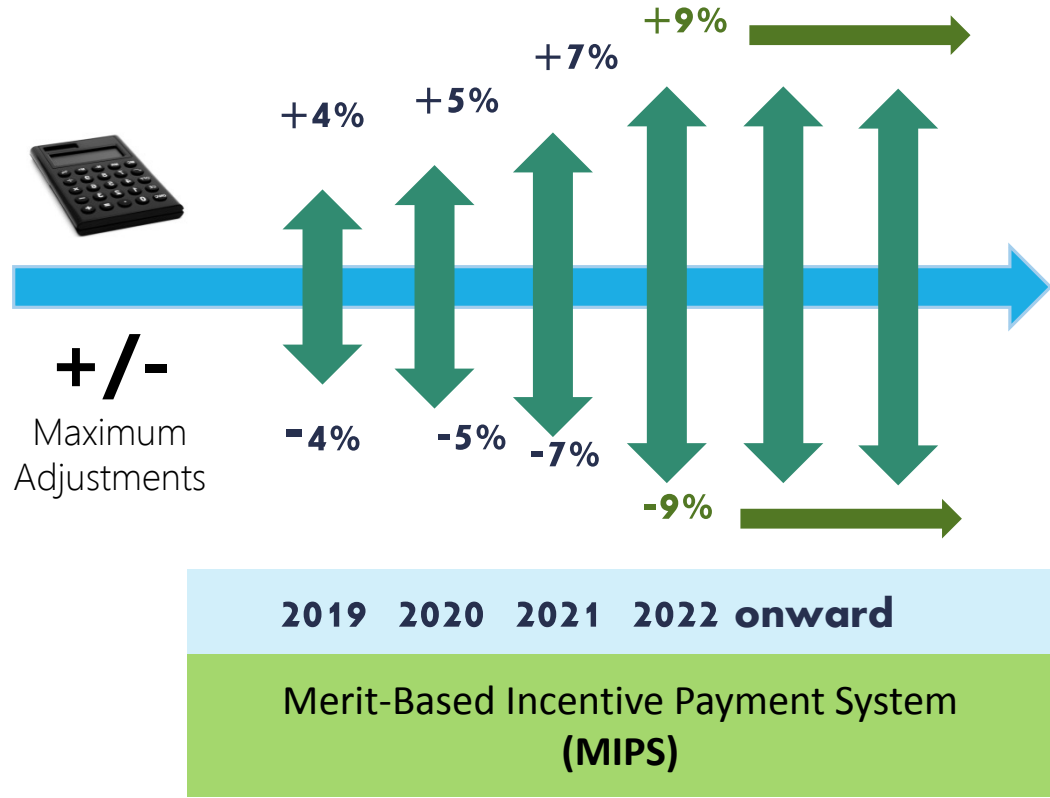
**IA**

<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ Attestation</li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>
<ul style="list-style-type: none"> <li>✓ <b>Attestation</b></li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> </ul>	<ul style="list-style-type: none"> <li>✓ <b>Attestation</b></li> <li>✓ QCDR</li> <li>✓ Qualified Registry</li> <li>✓ EHR Vendor</li> <li>✓ CMS Web Interface (groups of 25 or more)</li> </ul>



# How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.



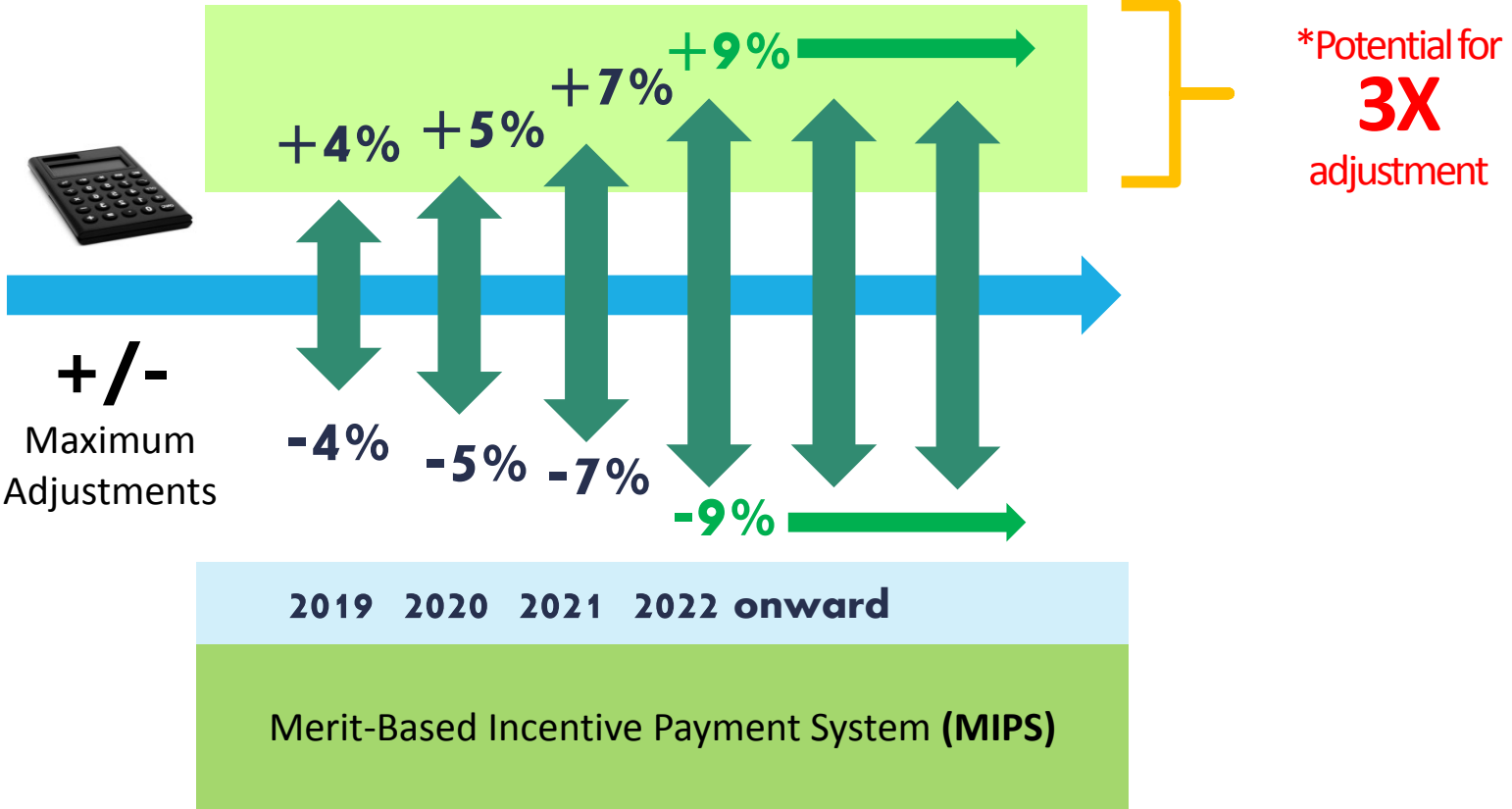
**Adjusted Medicare Part B payment to clinician**

The potential maximum adjustment % will increase each year from 2019 to 2022



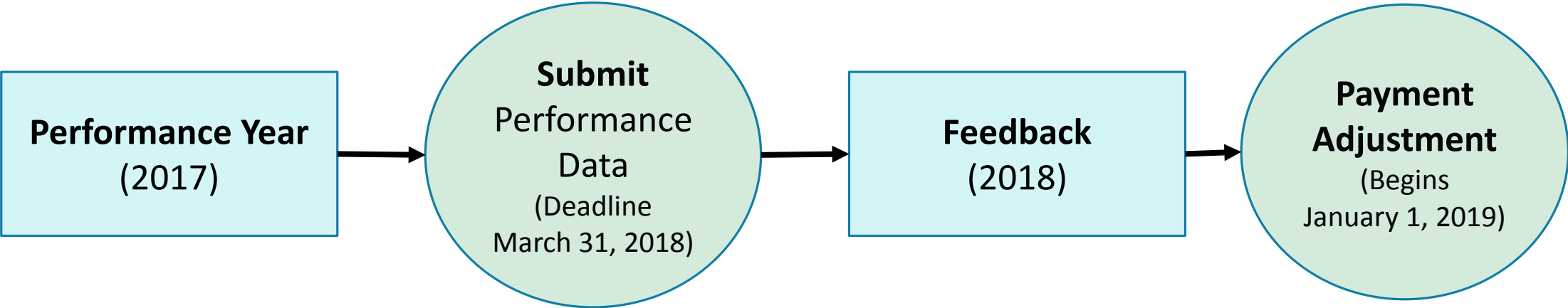
# How much can MIPS adjust payments?

**Note:** MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.





# Performance Period



Source: <https://qpp.cms.gov/>



# Final Rule MIPS Performance Period



**MIPS Performance Period  
(Begins 2017)**

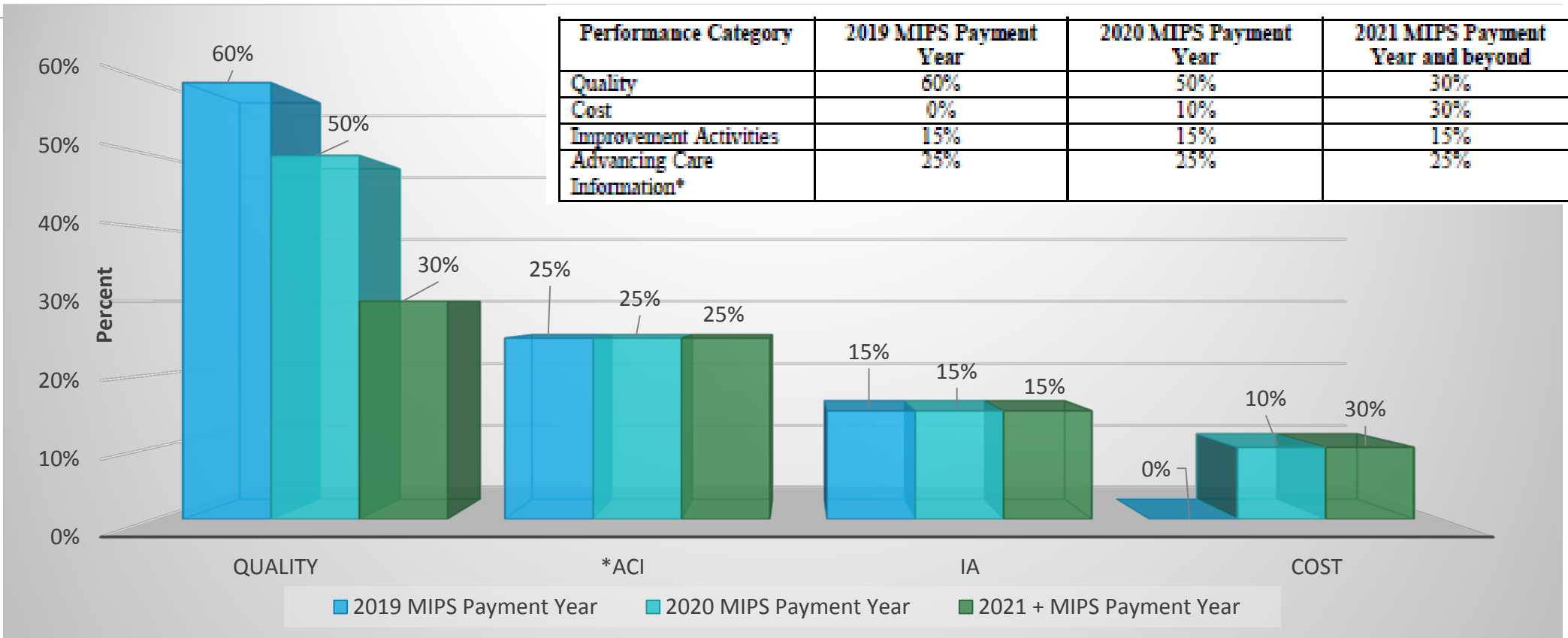
- ✓ All MIPS performance categories are aligned to a performance period of one full calendar year.
- ✓ Goes into effect in first year  
(2017 performance period, 2019 payment year).

	2017	2018	2019	2020	2021	2022	2023	2024	2025
<b>Performance Period</b>			<b>Payment Year</b>						



# Final Rule

## Percent Contribution to MIPS CPS by Year



\*Note: \*ACI -The weights for advancing care information could **decrease** (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.



# Incentives for Advanced APM Participation



# What is an Alternative Payment Model (APM)?

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

MACRA **does not change how any particular APM rewards value**.

APM participants who are not “QPs” will receive **favorable scoring under MIPS**.

Only **some** of these APMs will be **Advanced** APMs.





# Advanced APMs Must Meet Certain Criteria



To be an Advanced APM, the following three requirements must be met.

## The APM:

1

Requires participants to use **certified EHR technology**;

2

Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3

Either: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk**.



# Final Rule Advanced APMs



**Current APMs will be Advanced APMs in 2017**

✓ **Comprehensive ESRD Care (CEC) – Two Sided Risk**

Large dialysis organization (LDO) arrangement

Non-LDO arrangement

✓ **Comprehensive Primary Care Plus (CPC+)**

✓ **Medicare Shared Savings Program ACOs (Tracks 2 and 3)**

✓ **Next Generation ACO Model**

✓ **Oncology Care Model (OCM) (two-sided risk track available in 2018)**



# Future Advanced APM Opportunities



In 2018, CMS anticipates the following models will be Advanced APMs:

- ACO Track 1+**
- New voluntary bundled payment model**
- Comprehensive Care for Joint Replacement Payment Model**  
(Certified Electronic Health Record Technology (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1**  
(CEHRT track)
- Vermont Medicare ACO Initiative** (as part of the Vermont All-Payer ACO Model)

These lists will continue to change and grow as more models are proposed and developed in partnership with the clinician community and the Physician-Focused Payment Model Technical Advisory Committee

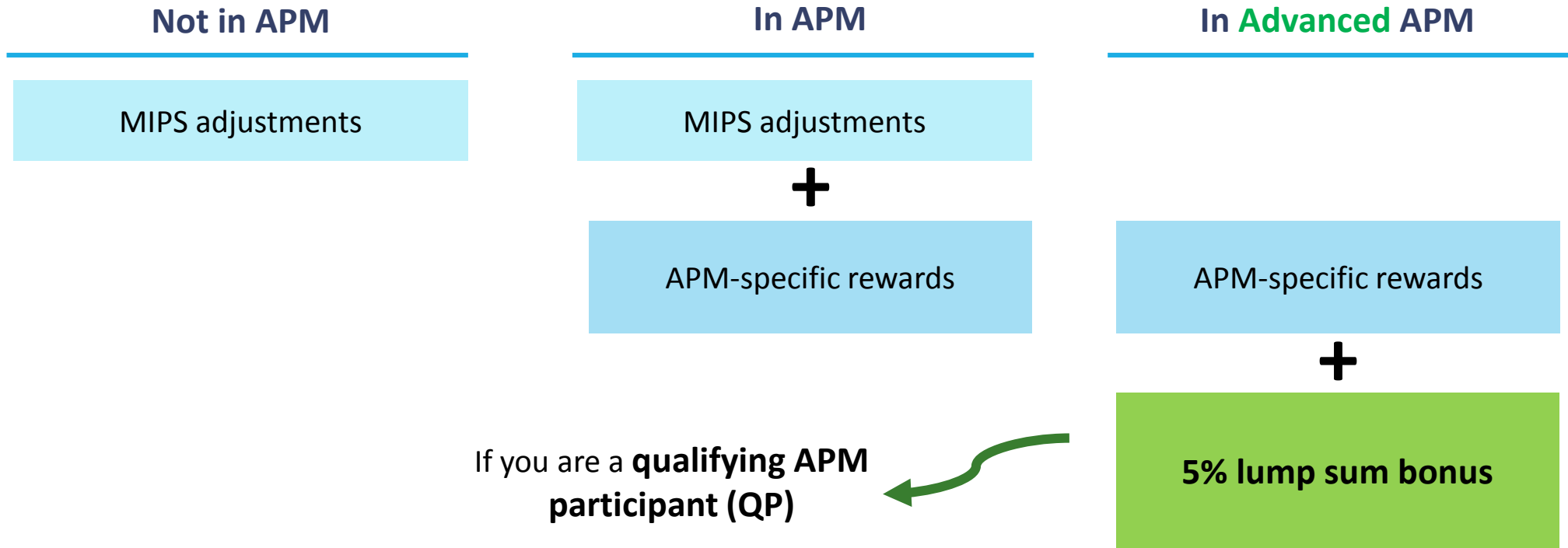


# Rewards for APM Participants

QPP provides **additional** rewards for participating in **APMs**.



## Potential financial rewards





# How do Eligible Clinicians become Qualifying APM Participants?—Step 1



1

- ✓ Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - ✓ individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - ✓ eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually.



# How do Eligible Clinicians become Qualifying APM Participants?—Step 2



2

- ✓ CMS will calculate a percentage “Threshold Score” for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

**These definitions are used for calculating Threshold Scores under both methods.**

**Attributed** (beneficiaries for whose cost and quality of care the APM Entity is responsible)

**Attribution-eligible** (all beneficiaries who could potentially be attributed)



# How do Eligible Clinicians become Qualifying APM Participants?—Step 2



2

✓ The two methods for calculation are Payment Amount Method and Patient Count Method.



Payment Amount Method

$\frac{\text{\$ \$ \$ for Part B professional services to attributed beneficiaries}}{\text{\$ \$ \$ for Part B professional services to attribution-eligible beneficiaries}}$

=

Threshold Score %



Patient Count Method

$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}}$

=



Threshold Score %



# How do Eligible Clinicians become Qualifying APM Participants?—Step 3



3 ✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment <u>or</u> patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
 Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
 Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%



# How do Eligible Clinicians become Qualifying APM Participants?—Step 4

4 ✓ All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.

Threshold Scores below the QP threshold = **no** QPs



Advanced APM



Advanced APM Entities



Eligible Clinicians



Threshold Scores above the QP threshold = QP status





# Final Rule

## QP Determination and APM Incentive Payment Timeline

2017	2018	2019
QP Performance Period	Incentive Payment Base Period	Payment Year

QP status based on Advanced APM participation here.

Add up payments for a QP's services here.

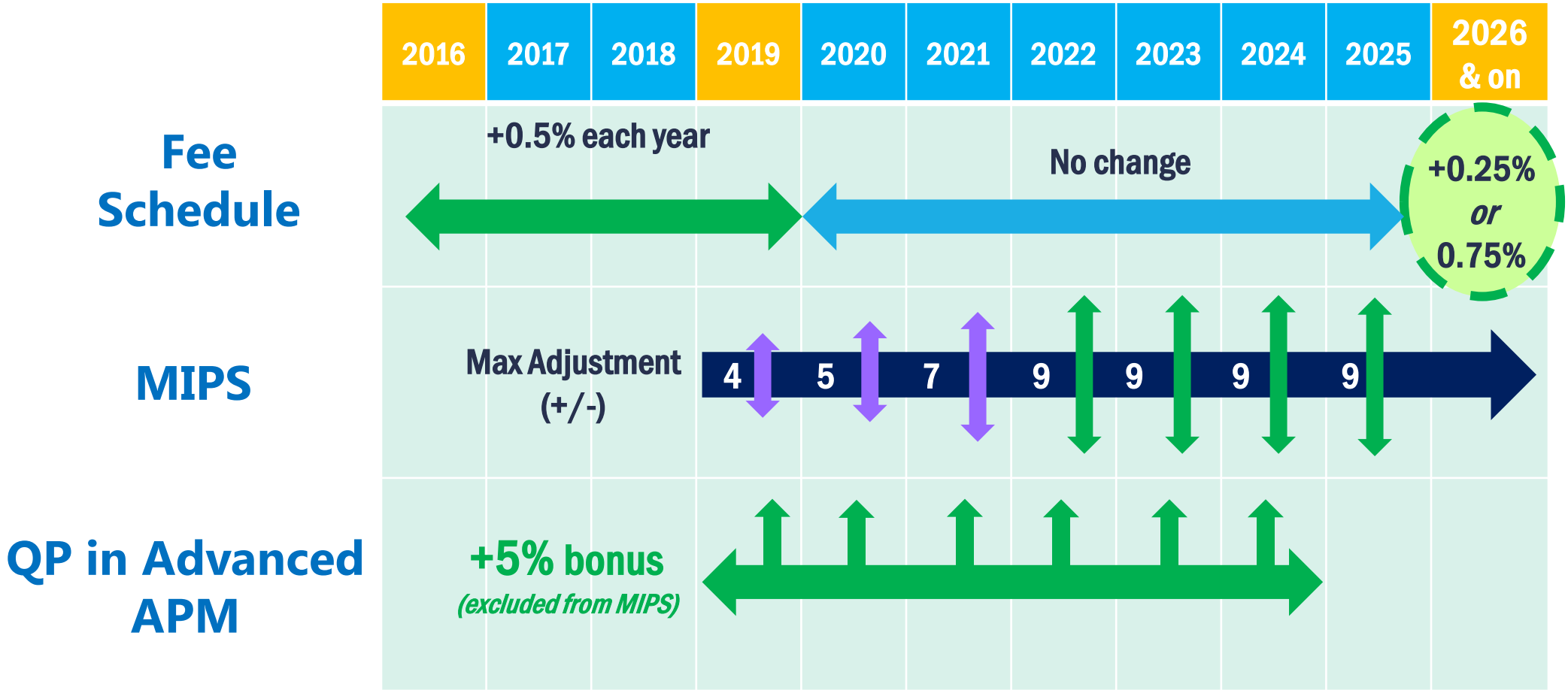
+5% lump sum payment made here.  
*(and excluded from MIPS adjustments)*

2018	2019	2020
QP Performance Period	Incentive Payment Base Period	Payment Year

Repeat the cycle each year...



# Putting it all together





# Getting Ready to Participate in MIPS



- Determine your eligibility status.
- Determine readiness and choose “how you want to start.”
- Choose if you will be reporting as an individual or group.
- Decide if you will work with a third party intermediary
  - ✓ Consider using Qualified Clinical Data Registry (QCDR).
- Choose data submission options.
  - ✓ Confirm your EHR is certified.
- Use CMS resources (website) to explore options on measures to use.



# Impact on IHS and Tribal Programs



- CMS supports the pursuit of developing Other Payer Advanced APMs under a variety of health care payment programs.
- Payment arrangements not included under Medicare Part B could potentially qualify as Other Payer Advanced APMs for performance periods in 2019 and later.
- IHS, Tribal and Urban Indian health care programs would be eligible for such a designation if they meet the criteria.



# Preparing for Quality Payment Program within the IHS



#	Immediate Action Items
1	Quality Measure assessment & development / IHS set of eCQMs for reporting
2	Measures reporting capability (submission from CEHRT or Registry)
3	Prepare for 2015 CEHRT
4	Assessment / Development of ACI (MU) measures
5	Clarify legality of IHS and Tribal participation in MSSP Tracks 2 and 3 and CPC+
6	Identify pathways for Improvement Activities in MIPS (e.g. PCMH Certified)
7	Support for I/T/Us in understanding and preparing for Quality Payment Program



# QPP / MACRA Next Steps for IHS



- Identify which Tracks you're taking
  - Can IHS and Tribes participate in advanced APM?
  - MIPS vs. Advanced APM
- Operationalize the Quality Payment Program
  - Data Call
  - Crosswalk Measures (eCQM with MIPS)
  - Define Roles and responsibilities
  - Provide Training and education
  - IHS Website and LISTSERV



# IHS QPP - MACRA Resources



IHS Website: <https://www.ihs.gov/qpp/>

LISTSERV Email: [MACRA@listserv.ihs.gov](mailto:MACRA@listserv.ihs.gov)

Subscribe URL: [https://www.ihs.gov/listserv/topics/signup/?list\\_id=357](https://www.ihs.gov/listserv/topics/signup/?list_id=357)





# Resources



Centers for Medicare & Medicaid Services. (November 2, 2016) Advanced Alternative Payment Models (APMs) in The Quality Payment Program (slide deck) Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html>

Centers for Medicare & Medicaid Services. MACRA: Delivery System Reform, Medicare Payment Reform. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

Centers for Medicare & Medicaid Services. Merit-Based Incentive Payment System: Advancing Care Information Performance Category. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf>

Centers for Medicare & Medicaid Services. The Merit-Based Incentive Payment Systems (MIPS). Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf>

Centers for Medicare & Medicaid Services. **Quality Payment Program: Modernizing Medicare to provide better care and smarter spending for a healthier America.** Available at: <https://qpp.cms.gov/>

Centers for Medicare & Medicaid Services. Quality Payment Program (slide deck). Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf>

Federal Register. Unpublished Rule 42 CFR Parts 414 and 495. Medicare Program: Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (to be published on 11/4/2016) Available at: <https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-and-alternative-payment-model-incentive-under>

Federal Register. Proposed Rule 42 CFR Parts 414 and 495. 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; Proposed Rule. May 9, 2016. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf>

Health Information and Management Systems Society. MACRA Resource Center. Available at: <http://www.himss.org/MACRA-resource-center>

American Medical Association. Medicare Payment Reform. Available at: <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page>

Zaroukian M. Medicare Access and CHIP Reauthorization Act of 2015: An Executive Overview of the Proposed Rule presentation. Health Information and Management Systems Society (HIMSS). 2016. Available at: <http://www.himss.org/Events/EventDetail.aspx?ItemNumber=48362>



# Questions



[susy.postal@IHS.gov](mailto:susy.postal@IHS.gov)