



hfma

healthcare financial management association

MACRA OVERVIEW

Agenda

- Overview of MACRA
- MIPS
- APM Incentive Payment
- Preparing for MACRA

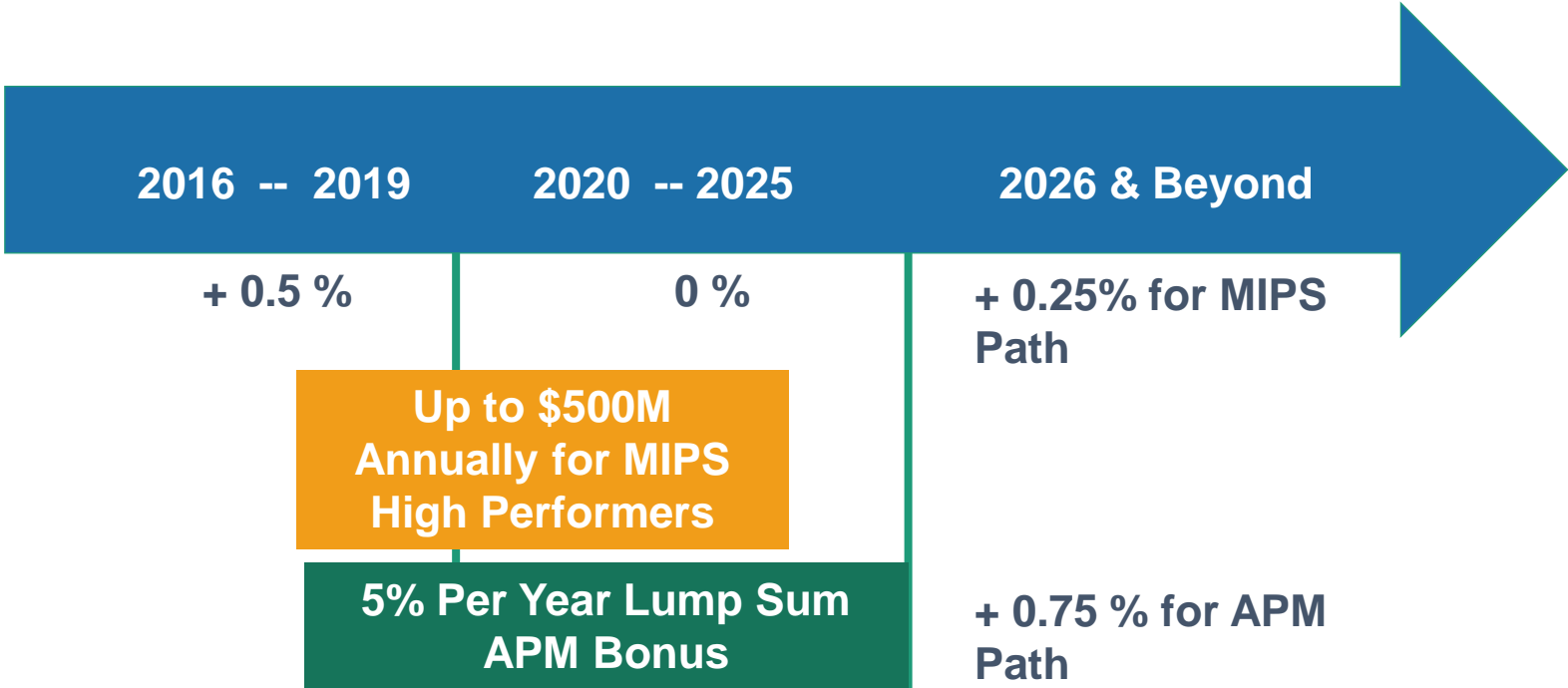
Overview of Medicare Access & CHIP Reauthorization Act of 2015

Passed Last Spring, MACRA Makes Three Significant Changes to Medicare Physician Payments

1. Ends the Sustainable Growth Rate (SGR) formula
2. Establishes Merit-Based Incentive Payment System (MIPS)
 - Consolidates PQRS, the Value Modifier, and Physician EHR Incentive Program
3. Establishes incentives for Alternative Payment Models (APMs)

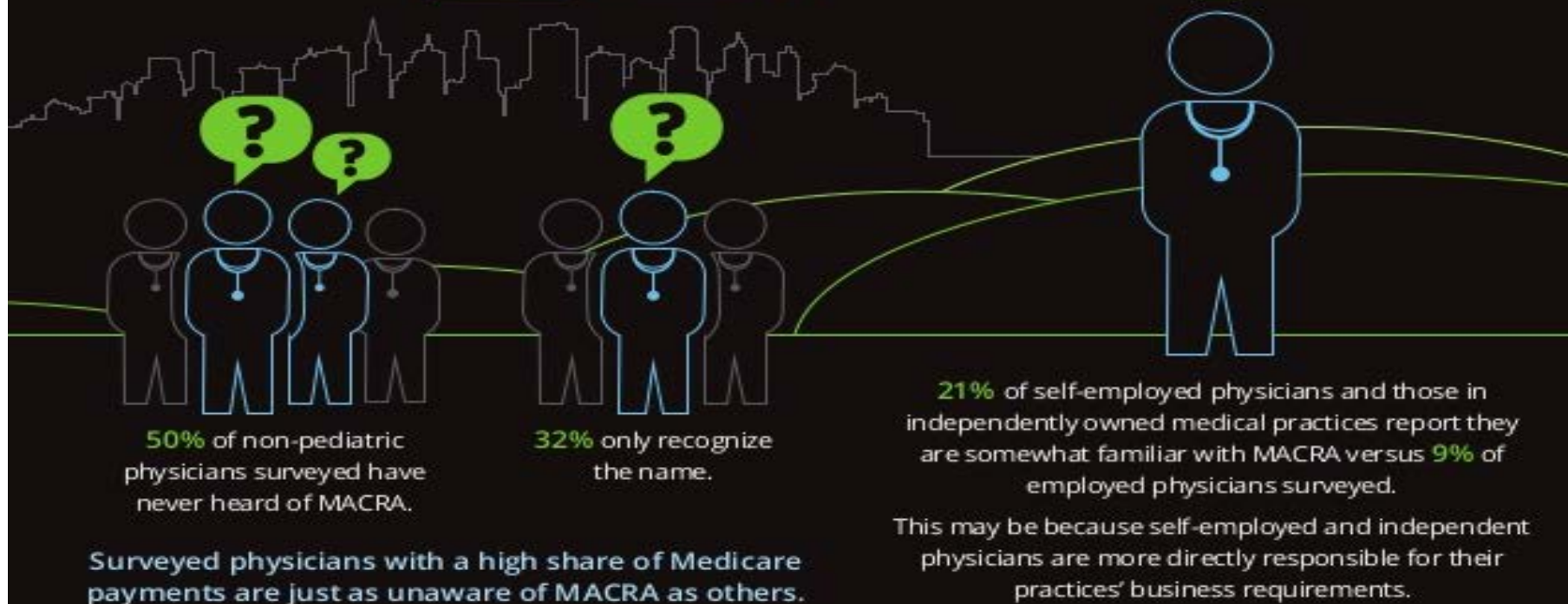
Payment Updates and APM Incentives

MACRA Replaces the SGR with Defined Annual Updates to Physician Fee Schedule Payments



Education Needed

The Majority of Physicians Were Unaware of MACRA at the Time of the Proposed Rule



Pick Your Pace

In Response to Provider Feedback CMS Is Providing Physicians with Options for Participating in MACRA's Quality Payment Program

2017 Participation Options

- Option 1: Test the Quality Payment Program
- Option 2: Participate for Part of the Calendar Year
- Option 3: Participate for the Full Calendar Year
- Option 4: Participate in an Advanced APM Model

MIPS Impact – Proposed Rule

CMS's Proposed Rule Significantly Disadvantaged Small Practices

MIPS PROPOSED RULE ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE

Practice Size	Number of Eligible NPIs (000s)	Positive MIPS Adj (\$, millions)	Negative MIPS Adj (\$, millions)	Net MIPS Adj (\$, millions)	Exceptional Performance Payment (\$, millions)	Net Impact of MIPS (\$, millions)	Impact as a % of Allowed Charges
Solo	103	65	(300)	(235)	40	(195)	-1.6%
2 - 9 Clinicians	123	182	(279)	(97)	113	16	0.1%
10 - 24 Clinicians	81	103	(101)	2	60	61	0.6%
25 - 99 Clinicians	148	147	(95)	52	84	136	1.1%
100 or More Clinicians	306	336	(57)	279	203	482	2.6%
Total	761	833	(832)	-	500	500	

MIPS Impact – Final Rule

CMS's Transitional Policies Have Lessened the Impact on Smaller Practices.

MIPS ESTIMATED PAYMENT YEAR 2019 IMPACT ON TOTAL ALLOWED CHARGES BY PRACTICE SIZE, STANDARD PARTICIPATION ASSUMPTIONS

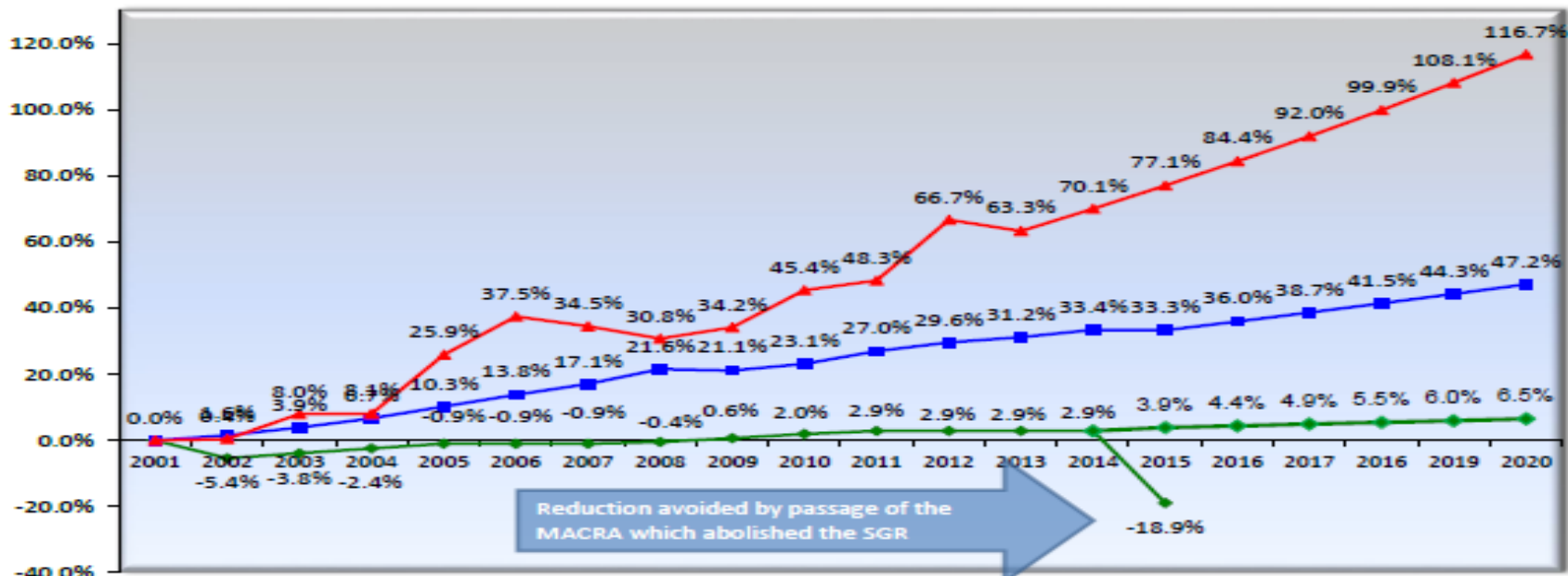
Practice Size	Number of Eligible NPIs (000s)	Positive MIPS Adj (\$, millions)	Negative MIPS Adj (\$, millions)	Net MIPS Adj (\$, millions)	Exceptional Performance Payment (\$, millions)	Net Impact of MIPS (\$, millions)	Impact as a % of Allowed Charges
1 - 9 Clinicians	148	72	-99	-27	145	118	0.5%
10 - 24 Clinicians	64	24	-37	-13	42	29	0.4%
25 - 99 Clinicians	132	31	-47	-16	54	38	0.4%
100 or More Clinicians	333	72	-16	56	258	314	1.1%
Total	677	199	-199	0	500	500	0.6%

Still Inadequate

Medicare FFS Payment Growth Is Not Keeping Up with Practice Expenses

Medical Group Management Association

Cumulative % Change Since 2001 for Physician Owned Multispecialty with Primary Care Only Groups for Operating Cost, the Consumer Price Index, and Medicare Physician Payments



Reduction avoided by passage of the MACRA which abolished the SGR

- * Source for change in operating cost: MGMA DataDive for Revenue and Expense
- * Operating cost values for 2015 to 2020 are moving average projections of previous years' data
- * CPI is the actual annual value 2001 through 2015, then increased by 2% (the "official" inflation target used by the U.S. Federal Reserve)



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Eligible Clinicians

The Quality Payment Program – MIPS and APM Incentive – Apply to the Following Provider Types:

- In years 2019 & 2020, it only applies to physicians, PAs, NPs, clinical nurse specialists, and CRNAs
- There are three groups that MIPS will not apply to:
 - Providers in their first year of Medicare Part B Participation
 - Providers who do not exceed a low-volume threshold
 - Qualifying or partially qualifying APM participants

Select Practice Settings

The MIPS Adjustment Applies to Physician Services Billed Under Method II Critical Access Hospitals But Not Under Federally Qualified Health Centers or Rural Health Clinics

- Applies to Method II CAH payments when MIPS eligible clinicians who practice in Method II CAHs have assigned their billing rights.
- Services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments.

Timing of Data/Scoring

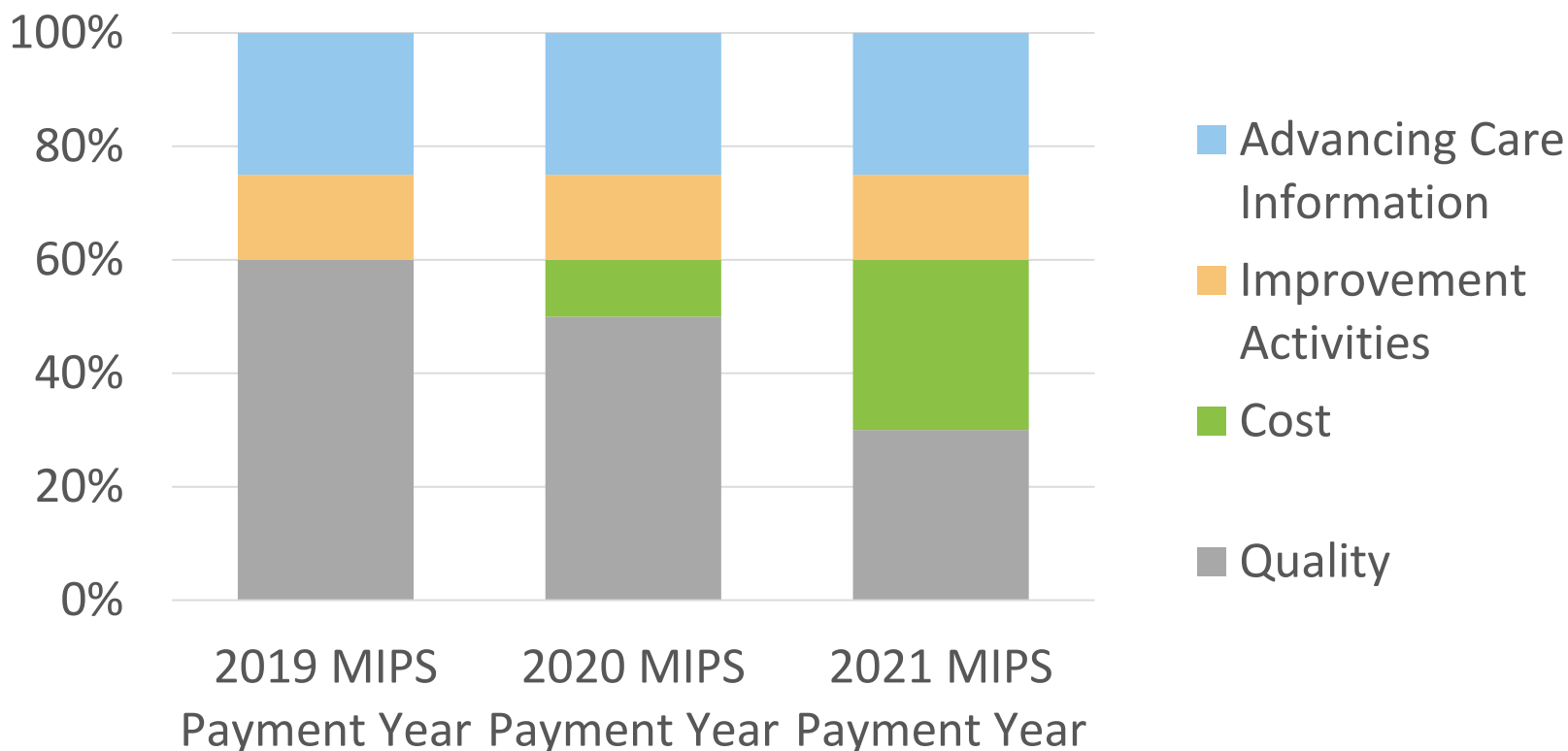
Similar to Other CMS Quality Payment Programs, MIPS Uses Data from Several Different Periods to Arrive at a Payment Adjustment

- CY 2017 is the “Performance Year” for the 2019 “Payment Year” for the:
 - Quality
 - Advancing Care Information (Meaningful Use)
 - Clinical Practice Improvement Activities
- The MIPS performance period is a minimum of one continuous 90-day period within CY 2017.
- CY 2015 Is the “Baseline Year” for Quality measures.

Category Weighting

Over Time the Cost Weighting Increases as the Quality Weighting Decreases

Final Weights by Performance Category



Quality – 60%

For the Applicable Performance Period, MIPS-Eligible Clinicians or Groups Must Report at Least Six Measures***

- At least one must be an **outcome measure**.
 - Report a “high priority” measure if there is no available outcome.
- Report all applicable measures if fewer than six measures apply.
- Subspecialists may submit a specialty-specific measure set in lieu of meeting the six-measure minimum requirement.

*Providers may avoid a negative adjustment by submitting at least one measure.

**Clinicians reporting via the CMS Web interface must report on all included measures for the 12-month performance period.

Quality Scoring Example

A Solo Clinician Submitting 6 “High Priority Measures,” All Above the Case Minimums, and Reporting Via Certified EHR Technology (CEHRT)

Quality Measure	High Priority	Performance Score	Quality Bonus	CEHRT Reporting Bonus	Total Points	Total Possible Points
Outcomes	Yes	4.1	N/A - 1 Required	1	5.1	10
Outcomes	Yes	9.3	2	1	12.3	10
Outcomes	Yes	8.4	2	1	11.4	10
Outcomes	Yes	9	2	1	12	10
Care Coordination	Yes	10	1	1	12	10
<u>Patient Experience</u>	<u>Yes</u>	<u>10</u>	<u>2</u>	<u>1</u>	<u>13</u>	<u>10</u>
Subtotal		50.8	9	6	65.8	60
Adj for Quality Cap		50.8	6	6	62.8	60
Calculated Performance Score						105%
Final Quality Score						100%

Resource Use – 0%

*For 2019, the Resource Use Category Carries No Weight.
However, It Will Increase to 10 Percent In 2020.*

- CMS will still calculate performance on resource utilization metrics for feedback purposes using CY 2017 data.
- Metrics are currently limited to the total cost per capita metric, Medicare Spend Per Beneficiary (MSPB), & select episode groups.
 - MSPB case minimum is 35
- CMS will continue developing care episode groups, patient condition groups, and patient relationship categories.
- In future years for ACOs, the cost category remains 0% and the 10 points are evenly allocated to the Improvement Activities and ACI Categories.

Episode Cost Measures

While Not Scored, Providers Will Receive Feedback on 10 Clinical Episodes Based on CY 2017 Performance

2019 Clinical Episodes for Feedback Purposes	
Mastectomy	Colonoscopy and Biopsy
Aortic/Mitral Value Surgery	Prostate Resection
CABG Surgery	Cataract Procedures
Hip/Femur Fracture or Dislocation Treatment	Hip Replacement
Cholecystectomy	Knee Replacement

A clinician must have a minimum of 20 cases to be scored on an episode-based measure.

Physician Reported Patient Relationship Codes

MACRA Requires Physicians to Report “Patient Relationship” Codes on Claims Filed as of Jan. 1, 2018

Draft Patient Relationship Categories

1. “Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care” (Acute Care)
2. “Clinician who provides continuing specialized chronic care to the patient” (Acute Care)
3. “Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode” (Continuing Care Relationship)
4. “Clinician who is a consultant during the acute episode” (Continuing Care Relationship)
5. “Clinician who furnishes care to the patient only as ordered by another clinician” (Acute Care or Continuing Care Relationship)

Advancing Care Info – 25%

The ACI Category Consists of a Base and Performance Score

- Clinicians Earn an Overall ACI Score of Up to 155 Points (Base + Performance), Capped at 100 Points.
- Clinicians Must Meet the Protecting Patient Health Information Measure to Earn Any ACI Score.
- In 2017, Clinicians May Use EHR Technology Certified to the 2014 Edition or the 2015 Edition or a Combination of Both.
- ACI Performance Will be Assessed at the Group, Instead of Individual Level.
- Hospital-Based Clinicians Are Exempt from the ACI Category. Related Points Will be Re-Weighted.

ACI – Base Score

The “Base Score” Accounts for 50% of ACI Category and Is Required to Receive Any ACI Points

Clinicians Must Submit the Numerator and Denominator, or Yes/No Statement for Each Measure within a Subset of Objectives:

1. Electronic Prescribing
2. Patient Electronic Access to Health Information
3. Coordination of Care Through Patient Engagement
4. Health Information Exchange
5. Public Health and Clinical Data Registry Reporting

ACI – Performance Score

A Clinician Can Earn Up to 90 Points if They Report All Measures in the Performance Score.

- Clinicians Choose the Measures to Report for Their Performance Score, Allowing Customization.
- Performance Scores Use a Numerator/Denominator to Build on the Base Score.
- Performance of 1-10% Earns 1 Point, Performance of 11-20% Earns 2 Points...
- The Public Health and Clinical Data Registry Reporting Objectives Are Binary.
- Bonus Points Are Available for Engagement with a Public Health or Clinical Data Reporting Registry.

Clinical Practice Improvement – 15%

The Maximum Number of Activities Required to Achieve the Highest Possible Score Was Reduced in the Final Rule

- To achieve the highest potential score – 40 points – providers must:
 - Report at **least two high-weighted** improvement activities or
 - Report at least **four medium-weighted** improvement activities, or
 - Report some combination of high and medium-weighted improvement
 - Participate in a certified medical home
- The maximum number of activities required for certain practices (e.g., rural providers) is reduced.
- CMS finalizes that MIPS-eligible clinicians or groups must perform improvement activities for at least 90 consecutive days.

CPIA Scoring Example

A Mid-Size Practice Performs One Medium- and One High-Weighted Activity in CY 2017

Activity	Classification	Weight (HPSA, Non-Patient Facing, Rural, or Small Practice?)	Total Score	Max Points
Participation in Transforming Clinical Practice Initiative	High	1	10	
Using Telehealth	Medium	1	20	
Total			30	40
Points Awarded		15	75%	11.25

Scoring Methodology

Performance Standards for Each of the MIPS Categories Varies

Performance Category	Final Performance Standard
Quality	Measure benchmarks used to assign points, plus bonus points with a minimum floor for all measures.
Cost	Measure benchmarks used to assign points.
Improvement Activities	<ul style="list-style-type: none">• Based on participation in activities listed in Table H of final rule• Based on participation as a patient-centered medical home• Based on participation as an APM• Number of points from reported activities or credit from participation in an APM compared against a highest potential score of 40 points

Scoring Methodology (cont.)

Performance Standards for Each of the MIPS Categories Varies

Performance Category	Final Performance Standard
Advancing Care Information	<p>Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure.</p> <p>Performance score: Between zero and 10 or 20 percent per measure (as designated by CMS) based upon measure reporting rate, plus up to 15 percent bonus score.</p>

“Transitional” Scoring Policy

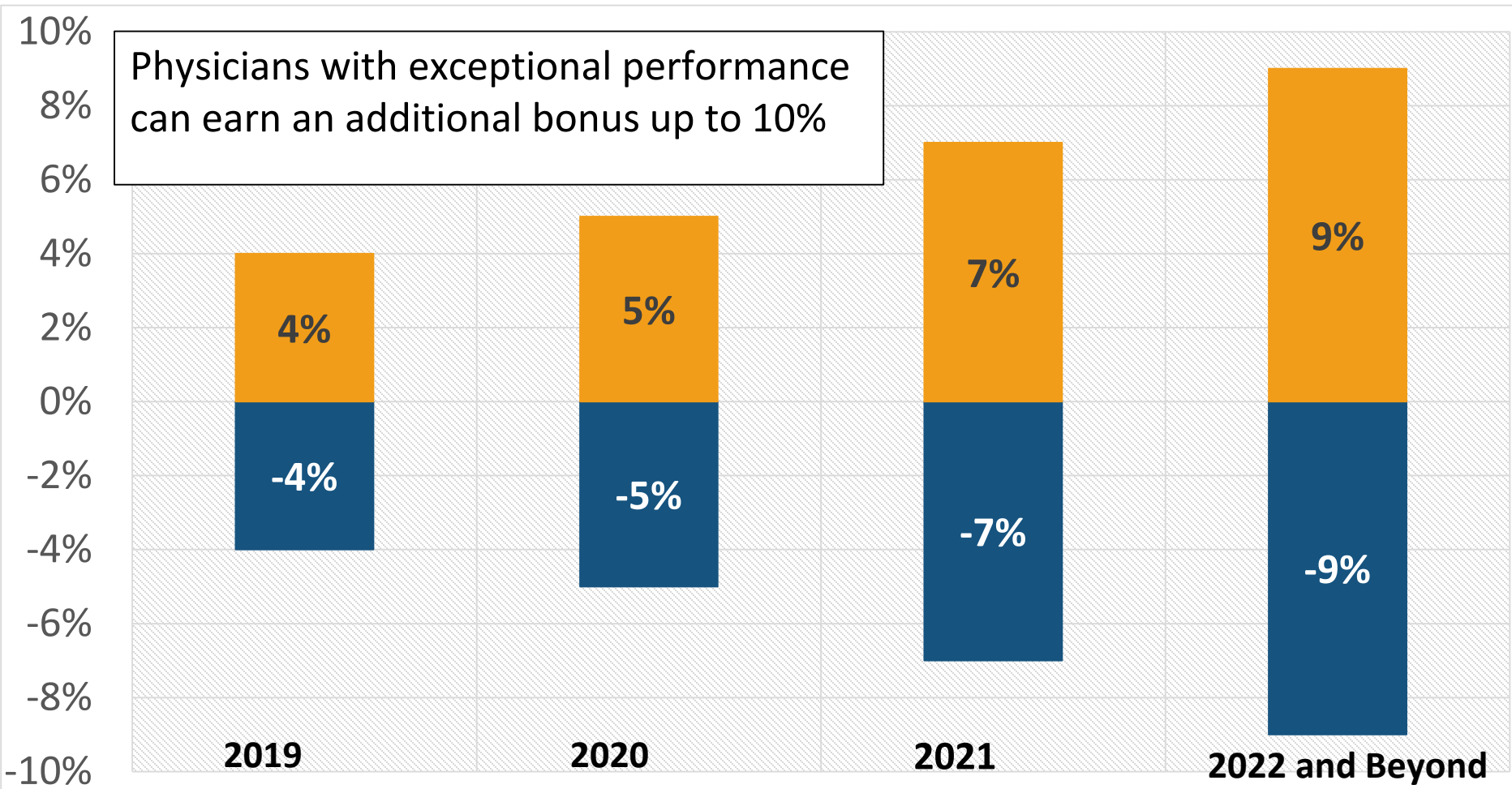
CMS Is Using Flexibility Provided By the Statute to Decrease Initial Reporting Requirements and Increase Participation in MIPS

CMS has created a transition year scoring methodology that does the following:

- Provides a negative 4% adjustment to clinicians who do not submit any data.
- Clinicians who submit data for any of the three categories for 90 days will not receive a negative adjustment.
- Clinicians who submit data for each performance category for at least a 90-day period, and have good performance may receive a positive adjustment.
- Clinicians who receive a final score at or above the additional performance threshold will receive a bonus.

MIPS Timeline and Implementation

Payment Adjustments to Base Rate of Medicare Part B Allowable Amounts Increase Over Time



Data Submission Mechanisms

MACRA Provides Clinicians Multiple Ways to Submit MIPS Data

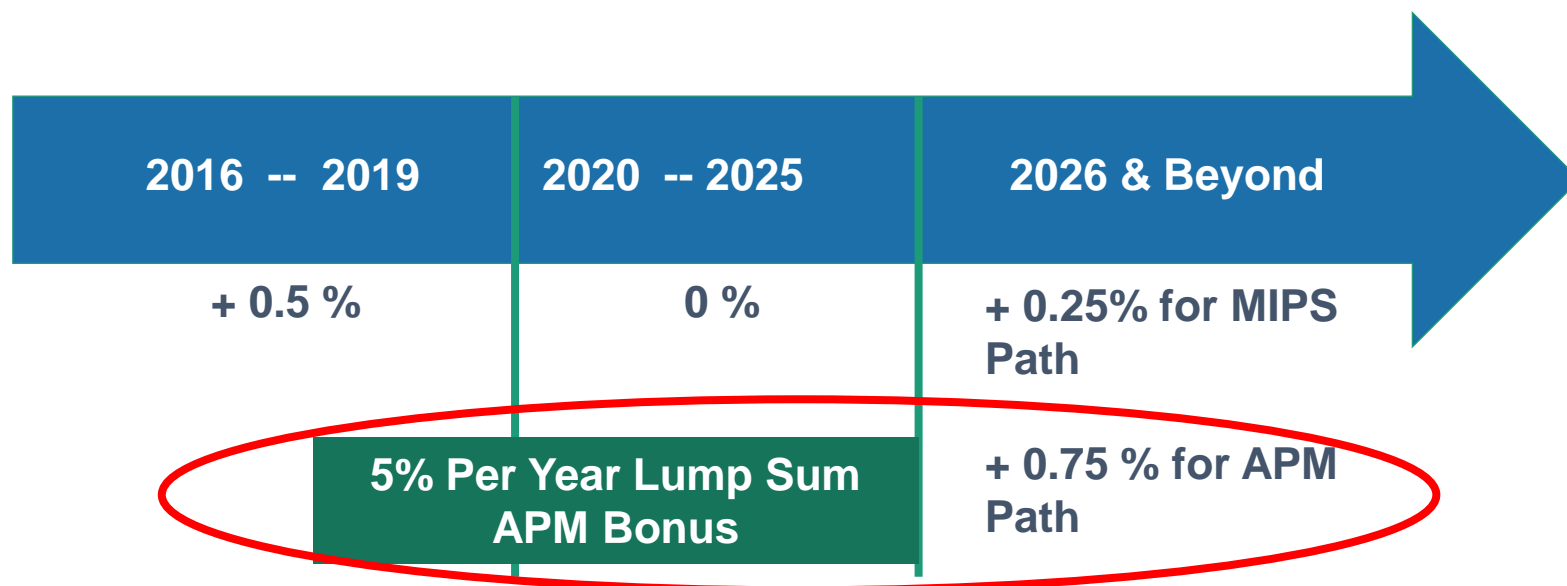
Performance Category	Individual Reporting	Group Reporting
Quality	<ul style="list-style-type: none"> • Claims • Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • QCDR • Qualified Registry • EHR Vendor • CAHPS Vendor • CMS Web Interface* • Administrative Claims
Resource Use	<ul style="list-style-type: none"> • Administrative Claims 	<ul style="list-style-type: none"> • Administrative Claims
Advancing Care Information	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*
Clinical Practice Improvement Activities (CPIA)	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor 	<ul style="list-style-type: none"> • Attestation • QCDR • Qualified Registry • EHR Vendor • CMS Web Interface*

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Advanced APM Incentives

MACRA Encourages Physicians to Participate in Advanced Alternative Payment Models



Advanced APMs (AAPMs)

To Qualify as an AAPM Participant, the Model and Physician Must Meet the Following Criteria:

Alternative Payment Model	<ul style="list-style-type: none"> ▪ A CMS Innovation Center Model ▪ Medicare Shared Savings Program ACO ▪ CMS Demonstration Project ▪ Demonstration required under law
Eligible Alternative Payment Entity	<ul style="list-style-type: none"> ▪ A payment model that requires participants to use certified EHR technology ▪ Provides for payment based on quality measures comparable to those in MIPS ▪ Bears more than nominal financial risk for monetary losses under the APM or is a medical home expanded under CMS Innovation Center authority
Qualifying APM Participant:	<p>A specified percent of the physician's payments or patient volume must be attributable to services furnished under an Alternative Payment Model.</p>

Medical Home – Nominal Risk

If Actual Expenditures Exceed Expected or the Medical Home Does Not Meet Performance on Specified Measure, the Payer Must Be Able to:

1. Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
2. Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians;
3. Require the APM Entity to owe payment(s) to CMS; or
4. Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

Medical Home – Nominal Risk

The Nominal Risk Standard for Medical Homes Escalates over time as shown in the table below.

Medical Home Model Nominal Risk Standard Total Risk Amounts	
Performance (Calendar) Year	Amount (% of the APM Entity's Total Parts A and B Revenue)
2017	2.5%
2018	3.0%
2019*	4.0%
2020 and beyond*	5.0%

*Under the All Payer Method, this becomes a total revenue test

Medical Home

Beyond Meeting Specific Risk Criteria, Medical Homes Must Have the Following Features to Qualify as an APM

- a. Include primary care practices or multi-specialty practices that include primary care physicians (PCPs)
- b. Empanel each patient to a PCP
- c. Perform at least four of the following activities:
 - i. Planned coordination of chronic and preventive care
 - ii. Patient access and continuity of care
 - iii. Risk-stratified care management
 - iv. Coordination of care across the medical neighborhood
 - v. Patient and caregiver engagement
 - vi. Shared decision-making
 - vii. Payment arrangements in addition to, or substituting for, fee-for-service payments

Medicare APM Nominal Risk

CMS Finalized Two Ways that a Non-Medical Home APM Can meet the Advanced APM Nominal Risk Standard

- 1) Revenue Standard: **8% or more** of the APM Entity's average Parts A and B revenue must be at risk in performance years 2017 and 2018.

Example: The providers have \$1M in Medicare allowable payments. They must be at risk of paying back losses of at least \$80K

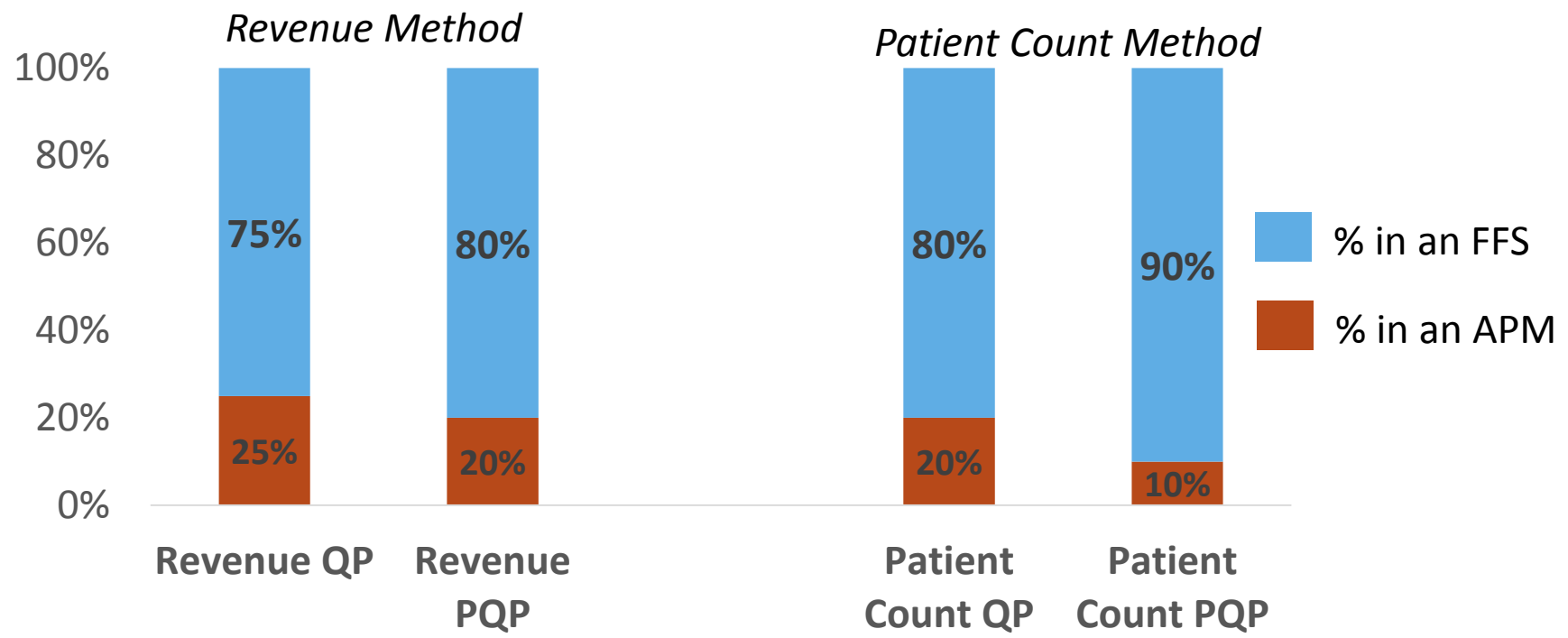
- 2) Benchmark Standard: **3% or more** of the expected expenditures for which an APM entity is responsible. Applies to all performance periods.

Example: A joint replacement episode target price is \$20K. The orthopedic surgeon must be at risk of paying back losses of at least \$600.

APM Medicare Volume Requirements

For 2019 and 2020, an APM Can Only Qualify for the Bonus by Having a Specific Percentage of Medicare Revenue or Patients in the AAPM

% of Medicare Payments or Patients Attributed to an APM Entity for Incentive Eligibility 2019 - 2020

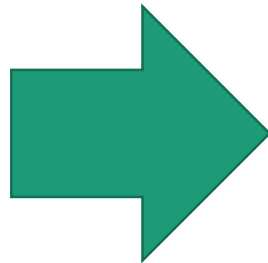


All Payer – Nominal Risk

For an APM to Qualify as “Advanced” Under the All-Payer Path, It Must Meet the Following Risk Requirements

AAPM Risk Requirements

- Bear marginal risk of at least 30%
- Be subject to a minimum loss ratio (MLR) of no more than 4%
- Bear total risk of 4% of expected expenditures



Examples of AAPM Financial Structures That Meet and Do Not Meet Requirements

	Benchmark	Actual	Marginal Risk Sharing Rate	Stop Loss	Amount Owed	Is Financial Risk Criterion Met?
Example 1	\$1,000,000	\$1,100,000	50%	15%	\$50,000	Yes
Example 2	\$1,000,000	\$1,100,000	60%	10%	\$60,000	Yes
Example 3	\$1,000,000	\$1,100,000	40%	3%	\$30,000	No
Example 4	\$1,000,000	\$1,100,000	100%	5%	\$50,000	Yes
Example 5	\$1,000,000	\$1,100,000	25%	10%	\$25,000	No

All Payer – APM Eligibility

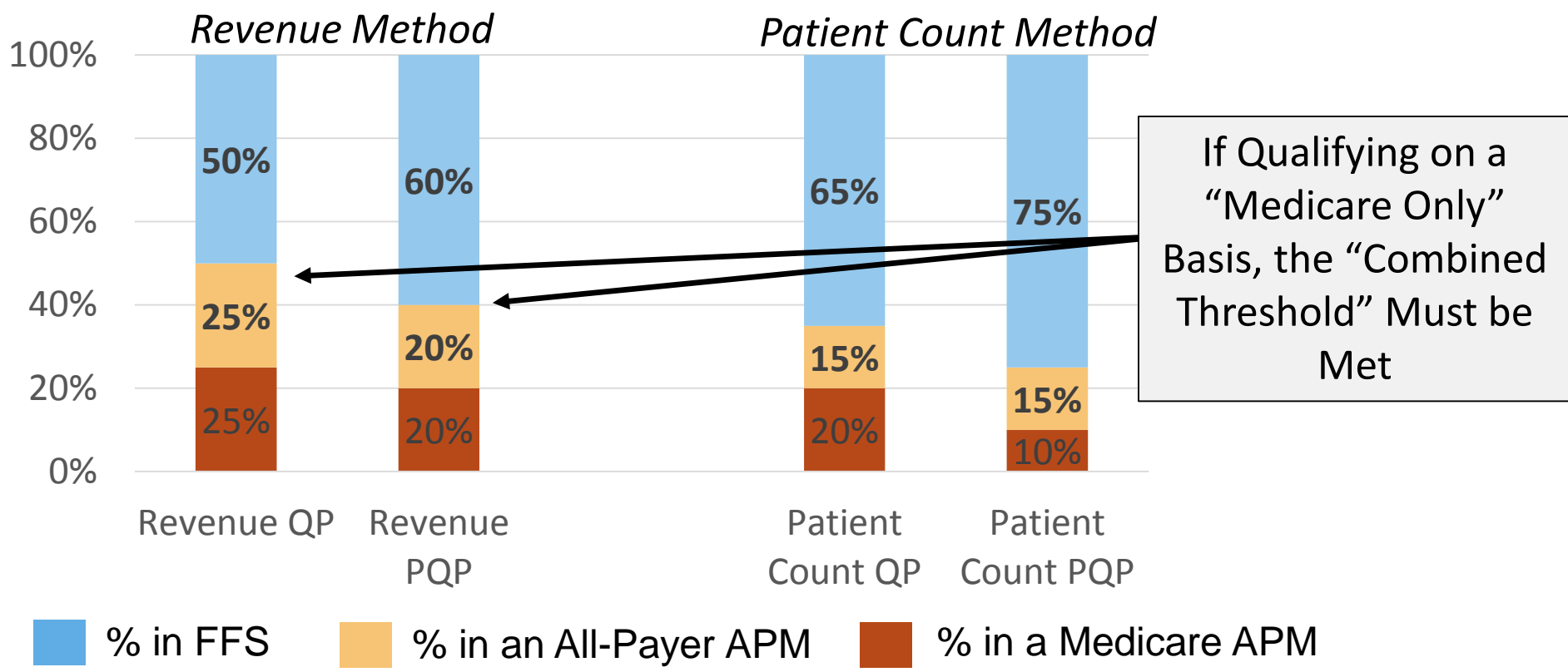
APM Entities Must Submit Documentation to CMS to Determine if an All-Payer APM Qualifies for the Incentive Payment

- 1) Contract specifics to assess whether each payment arrangement meets risk criteria.
- 2) Revenue data related to total business from the payer and specific to the risk contract.
- 3) Volume data related to the total business from the payer and specific to the risk contract.
- 4) Each payer attests to the accuracy of all submitted information, including the reported payment and patient data.

APM Volume Requirements

After 2020, an APM Entity Can Qualify for the Incentive on an All-Payer Basis

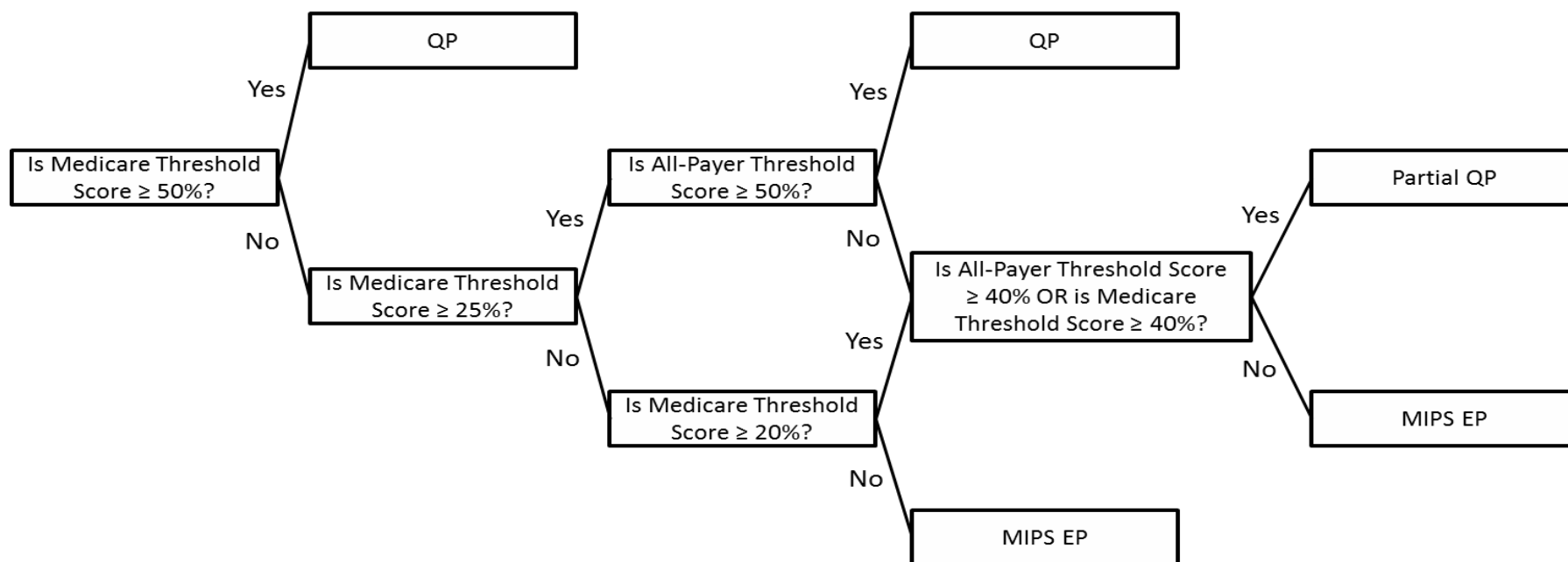
% of Payments or Patients Attributed to an APM Entity for Incentive Eligibility 2021 – 2022



All-Payer QP and PQP Determination

A Clinician Becomes an Eligible QP or PQP if It Meets the Following Revenue Test in 2021 or 2022

All Payer Option - Revenue Test: 2021 - 2022



All-Payer APM Example

This ACO Doesn't Meet the Revenue Threshold for the Incentive, but Partially Qualifies and Is Not Compelled to Report MIPS

TABLE 38: All-Payer Combination Option Example

Payer	Payments through ACO	Total Payments from Applicable Payer	Threshold Score
Medicare*	300,000	1,000,000	30%
Commercial	300,000	500,000	60%
Medicaid	80,000	100,000	80%
Total	680,000	1,600,000	43%

Meets the Minimum Medicare Threshold: (30% > 25%)

Does Not Meet the QP Threshold: (43% < 50%)

But Does Meet the PQP Threshold: (43% > 40%)

*For Medicare Part B amount tied to attribution Option.

Limited AAPM Options

Few Currently Available Medicare Models Qualify as AAPMs

APMs Meeting CMS's Risk Criteria in 2017 and 2018

- Comprehensive Primary Care Plus*
- MSSP Tracks 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care
- Oncology Care Model**
- CJR (2018)
- ACO Track 1+ (2018)***
- New Voluntary Bundled Payment Model (2018)***

*Practices of No More than 50 Providers Under the Corporate Umbrella After 2017

**Two-sided Risk Only

***Details TBD

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Key Questions

As Practices and Delivery Systems Prepare for MACRA They Need to Think Through Questions Such As:

- 1) Who are your eligible clinicians and how are they structured?
- 2) How much revenue is at risk under MIPS?
- 3) How have you performed to-date based on QRURs?
- 4) Which APMs are available for your organization to participate in?
- 5) What is your total Part A and B exposure if you pursue the APM Incentive Payment?
- 6) Can you meet the volume criteria to participate in the APM Incentive?
- 7) Do you anticipate other purchasers either creating APMs that would qualify or modifying existing programs?

Provide Education

Physicians and Stakeholders Need Education at a Variety of Touchpoints

Key Questions

- Which specialties will most impact the enterprise's results?
- Which stakeholders will most influence overall success?

Specific Activity

- Create a single presentation that can serve a variety of audiences.
- Provide resources introducing the basics and focusing on impact elements.
- Develop a calendar of ongoing organizational education sessions.

Assess Current State

Review Current QRUR Results and Past Value Modifier Performance

Key Questions

- Who has been involved in improving physician performance?
- Have these efforts been given sufficient resources?
- Are there success stories we can share to build engagement?
- How good is our ambulatory coding?

Specific Activity

- Perform drill downs on key indicators.
- Develop a MACRA workgroup that includes key stakeholders.
- Benchmark organization to others in market.
- Delineate coding issues from actual performance issues.

Plan Future State

Estimate the Reimbursement on the Table Across All Programs

Key Questions

- What's the enterprises total at risk/opportunity resulting from overlapping metrics?
- What are the enterprise's plans for participating in APMs and how will that impact the thresholds to qualify?

Specific Activity

- Model each year for the programs in which you participate.
- Understand volume thresholds for your org for the APM Incentive.
- Quantify org strategy taking into consideration the increased focus on quality/preventive care based on the crossover.

Model MIPS

Project How Your Organization Will Do in the First Year

Key Questions

- Where are you performing well?
- Where are there performance gaps?
- Which metrics should you submit based on projected performance?
- Where should you deploy resources to improve performance?

Specific Activity

- Model scenarios for enterprise under MIPS and APMs.
- Identify the best participation option for the organization.
- Assess analytic (current and planned) capability.
- Use current data to populate a performance dashboard(s).

Operationalize the Program

Determine the Governing Structure for Ongoing MIPS Decisions



Key Questions

- Which leaders (formal and informal) will have most influence on outcomes?
- What IT resources will need to be engaged?
- Who from contracting and reimbursement needs to be involved?



Specific Activity

- Include those who can remove implementation barriers .
- If choosing APMs, initiate planning process to meet volume thresholds.
- Combine physician and hospital quality reporting for all programs.

Tie to Enterprise

Link Overarching Strategy to Quality Programs

Key Questions

- What do we want to look like in 5 years?
- How does MACRA/APM participation interact/impact that goal?

Specific Activity

- Create process to evaluate participation in new payment models.
- Understand how MACRA fits into organizational planning.
- Monitor regulatory environment for additional changes to MACRA and APMs.

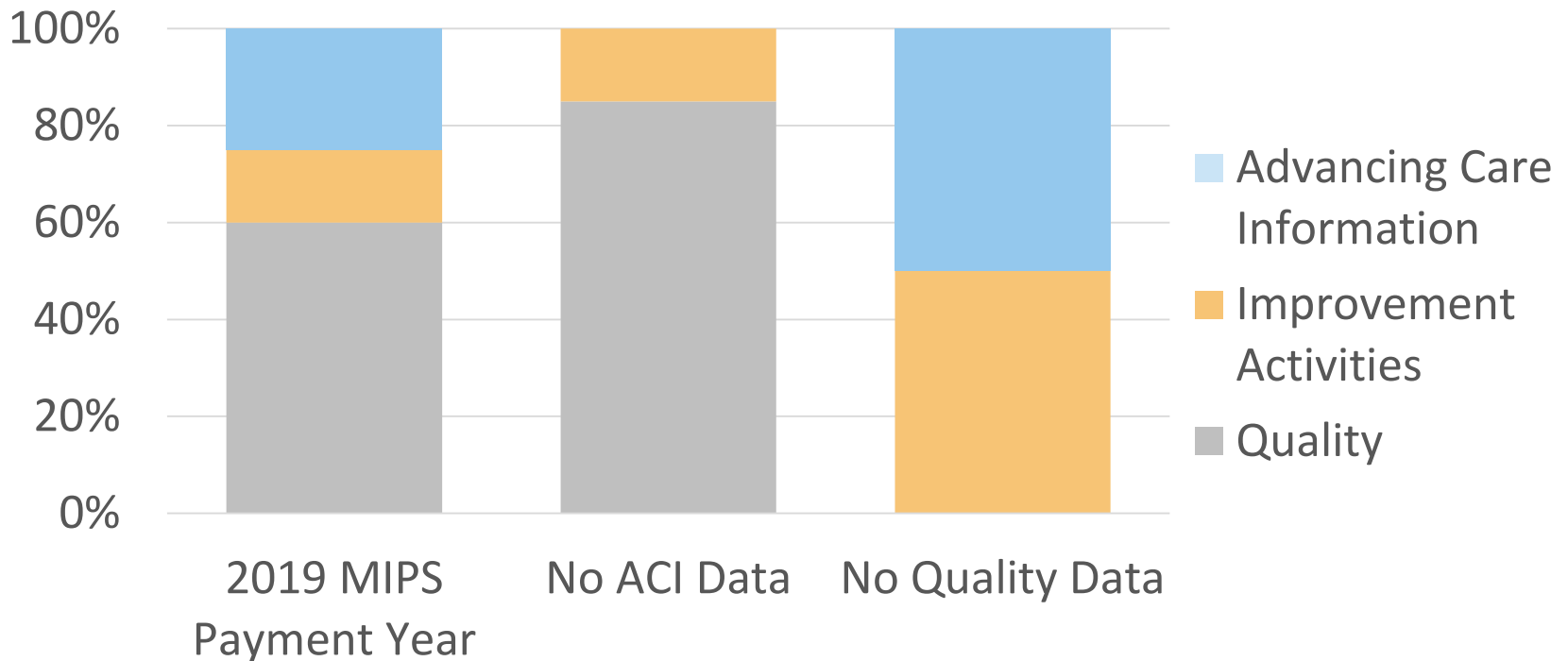
Important Dates

- **Jan. 1, 2015:** Beginning of Baseline Year for MIPS Quality Measures for CY 2019
- **Jan. 1, 2017:** Beginning of Performance Year for CY 2019 Payment Adjustment
- **June 30, 2017:** Deadline to register for CAHPS for MIPS or submit data via CMS Web Interface if you are using these reporting options in CY 2017.
- **Oct. 2, 2017:** Last date that the continuous 90-day period of time required for reporting can begin and end within the CY 2017 performance period.
- **Nov. 1, 2017 to Feb. 2018:** The survey administration period for the CAHPS for MIPS for CY 2017 performance period.
- **Jan. 1 – March 31, 2018:** CMS Web Interface submission timeframe. The submission deadline must be an 8-week period following the close of performance period CY 2017. The specific deadline during this timeframe will be published on the CMS website.
- **Jan. 2, 2018:** Submission period begins for the qualified registry, QCDR, EHR, and attestation submission mechanisms for CY 2017 performance period.
- **March 2, 2018:** Processing deadline for measures submitted via Medicare Part B claims for the CY 2017 performance period.
- **March 31, 2018:** Submission period ends for the qualified registry, QCDR, EHR, and attestation submission mechanisms for CY 2017 performance period.

Category Re-Weighting

If a Performance Category Lacks Data, CMS Will Allocate the Weighting to the Remaining Areas

2019 Payment Year Final Re-Allocated Weights



HFMA Resources

HFMA Has Developed Resources to Help You Prepare for MACRA

- Reg Summary: <http://www.hfma.org/2015factsheets/>
- Implementation Placemat:
<http://www.hfma.org/Content.aspx?id=50335>
- Implementation Articles and Webinars:
<http://www.hfma.org/Physician/>

Questions?

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