2018 Washington Update

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Associate Director

MGMA Government Affairs
Agenda

• Current political and legislative environment
• The evolving federal payment landscape
• Other Trending topics
• MGMA Advocacy Priority: Regulatory Relief
• Q&A
Current Political and Legislative Environment
Legislative Watch List

What’s happening now in Congress
- Opioid efforts
- Drug pricing and transparency
- Government budget expires Sept. 30

Latent health policy issues
- Entitlement reform
- Repeal and replace ACA
- Stabilize individual health insurance markets

Midterm elections on Nov. 6
Bipartisan Budget Act of 2018
Passed into law on February 9, 2018

Technical Amendments to MACRA make several changes that MGMA has been strongly advocating for, including:

- Excludes Medicare Part B drug costs from MIPS payment adjustments and from the low-volume threshold determination.
- Eliminates improvement scoring for the cost performance category for the third, fourth, and fifth years of MIPS.
- Allows CMS to reweight the cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS.
- Allows CMS flexibility in setting the performance threshold for years three through five to ensure a gradual and incremental transition to the performance threshold set at the mean or median for the sixth year.
- Allows the Physician Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback regarding the extent to which models meet criteria and an explanation of the basis for the feedback.

Reducing EHR Significant Hardship:

- Removes the current mandate that meaningful use standards become more stringent over time. This eases the burden on physicians as they would no longer have to submit and receive a hardship exception from HHS.
Bipartisan Budget Act of 2018
Passed into law on February 9, 2018

Additional provisions in the Act that are important to medical groups:

- Eliminate the unelected Medicare cost-cutting board known as the IPAB.
- Permanently repeal the Medicare therapy payment cap.
- Expand coverage for telehealth services.
- Extend the work Geographic Practice Cost Index (GPCI) 1.0 floor for two years through 2019.
- Extend Children's Health Insurance Program funding for an additional four years through fiscal year 2027.
VA MISSION Act of 2018

Congress passed bipartisan legislation to fix VA Choice program

• Creates prompt payment standards to reimburse community providers within 45 days for clean paper claims and 30 days for clean electronic claims

• Removes 30-day/40-mile requirement for veterans’ care in the community

• Requires the VA Secretary to develop an education program to inform veterans and VA providers about veterans’ health care options

Recent government watchdog report itemizes administrative burdens in VA Choice program, including poor communication between VA contractors and providers
The Evolving Federal Payment Landscape
Evolving Federal Payment Landscape

**FACT OR FICTION?**

**MIPS is over**

Medicare’s payment advisory commission **recommended** that Congress replace MIPS with a new quality payment program that would withhold a percentage of Medicare payments to fund performance bonuses based on a small set of mandatory cost and quality measures calculated by CMS entirely from claims data.

**Reality Check:**

- MedPAC’s recommendations are purely advisory and hold no force of law unless Congress acts on them. Congress has shown no sign of wavering in its bipartisan support of MACRA.
- MGMA is currently working with Congress and the Administration to make substantial changes to the QPP to bring it more into alignment with Congress’ original vision.
Evolving Federal Payment Landscape

FACT OR FICTION?

Medicare is re-rebranding Meaningful Use?

CMS announced Meaningful Use and the Advancing Care Information (ACI) category of MIPS will be called "PROMOTING INTEROPERABILITY."

Reality Check: ✓

• New Administrations like to put their own rubber stamp on existing programs.
• It does not yet reflect any substantial, policy changes. Those will come in the 2019 QPP rulemaking cycle.
MIPS Timeline for 2017 Performance Period

**April 3, 2018**
2017 MIPS data submission period closed

**Spring 2018**
CMS provides preliminary feedback

**June 29, 2018**
MIPS final score and feedback now available

**Jan. 1, 2019**
CMS begins applying payment adjustments to each Part B claim
<table>
<thead>
<tr>
<th>Policy</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penalty or bonus</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>Reporting period</td>
<td>Any 90 days</td>
<td>Quality and cost: full calendar year ACI and IA: any 90 days</td>
</tr>
<tr>
<td>Category weights</td>
<td>Quality: 60%</td>
<td>Quality: 50%</td>
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<tr>
<td></td>
<td>ACI: 25%</td>
<td>ACI: 25%</td>
</tr>
<tr>
<td></td>
<td>IA: 15%</td>
<td>IA: 15%</td>
</tr>
<tr>
<td></td>
<td>Cost: 0%</td>
<td>Cost: 10%</td>
</tr>
<tr>
<td>Small practice bonus</td>
<td>None</td>
<td>5 points</td>
</tr>
<tr>
<td>Complex patient bonus</td>
<td>None</td>
<td>5 points</td>
</tr>
<tr>
<td>Low volume threshold</td>
<td>$30,000 Medicare charges or 100 patients</td>
<td>$90,000 Medicare charges or 200 patients</td>
</tr>
<tr>
<td>CEHRT edition</td>
<td>2014 or 2015</td>
<td>2014 or 2015</td>
</tr>
</tbody>
</table>
MIPS Policies: 2019 *(PROPOSED)*

**POLICY** | 2019
--- | ---
Penalty or bonus | +/- 7%
Reporting period | Quality and cost: full calendar year  
ACI and IA: any 90 days
Category weights | Quality: **45%**  
Promoting Interoperability: **25%**  
Improvement Activities: **15%**  
Cost: **15%**
Small practice bonus | 5 points
Complex patient bonus | 5 points
Low volume threshold | $90,000 Medicare charges, 200 patients, or 200 covered services
CEHRT edition | 2015

Download the analysis of the proposed Medicare PFS and QPP rules prepared by MGMA Government Affairs.
In 2018, clinicians will need to verify their MIPS participation at the QPP website.

CMS will not be mailing notices this year.

MGMA has pressed CMS since the start of the year to release this information. Because of this delay, we are strongly advocating for a return to 90 day reporting for all MIPS performance categories.

For your 2018 MIPS participation status, visit: qpp.cms.gov/participation-lookup
A group reporting to MIPS might have clinicians who, by themselves, are not eligible to participate in MIPS due to these three scenarios:

- Newly Enrolled in Medicare
- Qualified APM Participant
- Below Low-Volume Threshold

In group reporting, clinicians who are newly enrolled in Medicare, or are Qualified APM Participants (QPs), are still excluded from MIPS. Payment adjustments to group will not apply to these clinicians.

However, if the group exceeds the low-volume threshold clinicians who themselves fall below the low-volume threshold are included and must report MIPS data.
MIPS Group Participation in 2018

REPORTING MECHANISMS

Groups must register to use the CMS Web Interface and/or CAHPS for MIPS Survey by June 30, 2018

Only groups of 25 or more eligible clinicians can report via the CMS Web Interface. Groups that participate in MIPS through qualified registry, qualified clinical data registry, or electronic health record (EHR) data submission mechanisms do not need to register.

All other sized groups can participate in the CAHPS for MIPS survey.

Register at the Quality Payment Program website between April 1, 2018 through June 30, 2018.

Please note, if your group was registered to participate in MIPS in 2017 via the CMS Web Interface, CMS automatically registered your group for 2018 CMS Web Interface participation. You may edit or cancel your registration at any time during the registration period. Automatic registration does not apply to the CAHPS for MIPS survey.
MIPS Year 2 – 2018

HOW TO GET TO 100 POINTS

Quality
- 50 points

Cost
- 10 points

Advancing care information
- 25 points

Improvement activities
- 15 points

MIPS Final Score
- 0-100 points

MINIMUM PERFORMANCE PERIOD

12 Months

12 Months

90 Days

90 Days

SEE APPENDIX FOR MORE INFORMATION ON MIPS PERFORMANCE CATEGORIES
2018 MIPS Payment Adjustments

ECs and groups assigned final score of 0-100 points based on performance.

Final score compared to performance thresholds set by CMS each year.

Scores above threshold result in a bonus; scores below threshold get a penalty.

Payment adjustment in 2020

- Final MIPS score in 2018: 0-100 points
- 70 points = exceptional bonus
- 15 points = break even point
- ≤ 3 points = -5% reduction

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**PAYMENT ADJUSTMENTS**

How can I achieve 15 points?

- Report all required Improvement Activities
- Meet ACI base score and submit 1 Quality measure that meets data completeness
- Meet ACI base score, by reporting the 5 base measures, and submit one medium-weighted IA
- Submit 6 Quality measures that meet data completeness criteria

**BONUSES**

Small Practice Bonus: 5 Points

- Complex Patient Bonus: 5 Points

Must submit data for at least one MIPS category to be eligible.

*CMS will apply a complex patient bonus capped at 5 points using the dual eligibility ratio and average Hierarchical Condition Category (HCC) risk score.

**HARDSHIPS**

New automatic hardship granted to those in areas impacted by natural disasters.

- CMS uses practice location from PECOS & FEMA-designated disaster areas.

ECs/groups have option to submit, receive score, & receive a payment adjustment.
### 2018 Advanced APMs

<table>
<thead>
<tr>
<th>APM Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP Tracks 2 &amp; 3 and the new Track 1+ *</td>
<td></td>
</tr>
<tr>
<td>Next Generation ACOs</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care Plus (CPC+)</td>
<td></td>
</tr>
<tr>
<td>Comprehensive ESRD Care - 2-sided risk †</td>
<td></td>
</tr>
<tr>
<td>Oncology Care Model - 2-sided risk †</td>
<td></td>
</tr>
<tr>
<td>Comp Care for Joint Replacement (CEHRT track) *</td>
<td></td>
</tr>
</tbody>
</table>

* = not currently accepting new applicants

† = New opportunity in 2018

**NEW APM – BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) ADVANCED**

First cohort of participants will start participation in the model on October 1, 2018. The model performance period will run through December 31, 2023 and a second application opportunity will open in January 2020.

CMS BPCI Advanced Website
MIPS/APMs Physician Practice Action Steps

- **Assess** performance under past reporting programs
- **Evaluate** vendor readiness & costs (ask about 2015 CEHRT!)
- **Protect** your practice against a MIPS penalty
- **Determine** your 2018 MIPS goal; establish a reporting strategy
- **Comply** with deadlines (hardship exception, CAHPS for MIPS, MSSP, etc.)
- **Analyze** data at year-end; hone final reporting strategy
- **Leverage** MGMA resources to educate yourself, your physicians and staff
2018 PFS Calculation

Total RVUs from fee schedule

Conversion factor

Adjusted for:
- Complexity of service and expenses
  - Work RVU
  - FE RVU
  - RI RVU

Geographic factors
- Work GPCI
- FE GPCI
- PI GPCI

Payment modifier

Adjusted fee schedule payment rate

Policy adjustments (multiplicative)

Provider type
- Non-physician billing independently
- Non-participating

Geographic
- HPSA bonus

Performance in quality programs
- Physician Quality Reporting System
- Meaningful use of certified electronic health records
- Value-based payment modifier

Payment
### 2018 Key Policies in PFS

<table>
<thead>
<tr>
<th>Policy</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-excepted, off-campus provider-based hospital outpatient department payment rates equivalent to 40% of OPPS payment rate (down from 50% in 2017). Adjustment will level playing field between hospitals and physician practices.</td>
<td></td>
</tr>
<tr>
<td>Mandatory consultation of appropriate use criteria for advanced imaging services</td>
<td>delayed until 2020.</td>
</tr>
<tr>
<td>MACRA patient relationship HCPCS modifiers may be voluntarily reported beginning Jan. 1.</td>
<td></td>
</tr>
<tr>
<td>Medicare Diabetes Prevention Program starts April 1.</td>
<td></td>
</tr>
</tbody>
</table>
Digital Health Services in 2018

**TELEHEALTH**

Eliminated required use of GT modifier on telehealth claims; distant site providers will continue to use Place of Service (POS) code 02.

Added 7 new codes to list of covered codes.

Statutory restrictions on geographic location, originating site, and eligible provider type still in place.

**REMOTE PATIENT MONITORING**

CMS finalized separate payment for RPM services by unbundling CPT code 99091 – collecting and interpreting physiologic data.

RPM services are not subject to the same strict requirements as telehealth, but must meet CPT criteria to be reimbursable.

**Ten action steps** for incorporating data from patient wearables into an EHR
Proposed 2019 Medicare Payment Rule

RVU & Conversion Factor

• Proposed 2019 PFS CF is $36.05, a slight increase above the 2018 PFS CF of $35.99
• Updates to RVUs

Virtual Visits & Remote Patient Monitoring

• Medicare proposes to pay providers for audio and visual communications that substitute for an in-person visit
• New CPT codes for RPM
• Clarifies these services are not subject to telehealth reqs (patient must be in rural location and not at home, e.g.)
CMS E/M 2019 Proposed Revisions

Documentation: Reduce all requirements to level 2
Payment: Collapse levels 2-5 into one single level for new v. established patients; Create add-ons for certain visits; Reduce payment when modifier 25 is used

MGMA and 170 other medical associations/societies to CMS in Aug. 27 letter:
• Do not collapse payment levels as proposed
• Collapsing payment rates risks hurting physicians and groups that treat complex patients
• Finalize proposed policies to simplify documentation aspects of E&M
MGMA Resources

**Washington Connection** ([link](#))
Subscribe to receive our weekly e-newsletter with breaking updates and everything you need to know from our nation’s capital.

**Speak directly with MGMA Government Affairs experts**
We would like to hear from you!
202.293.3450  |  govaff@mgma.org

**Dedicated member e-groups** ([link](#))
For instance, you can discuss MIPS and APMs with 3,400 MGMA peers and MGMA Government Affairs on the Medicare Value-Based Payment Reform e-group.
Other Trending Topics
MGMA Stat Poll on Prior Authorization

IN THE PAST YEAR, PAYER PRIOR AUTHORIZATION REQUIREMENTS HAVE:

- 86% INCREASED
- 11% STAYED THE SAME
- 3% DECREASED

MAY 16, 2017 POLL
1041 APPLICABLE RESPONSES OUT OF 1095 TOTAL RESPONSES.
FOR MORE INFORMATION, VISIT MGMA.ORG/POLLS.

Excessive prior authorization requirements negatively impact our healthcare system.

- Disrupts continuity of care
- Interferes with physician-patient relationship
- Increases administrative burden and cost
January 2018 Provider/Plan Joint Statement on Prior Authorization

Reduce the number of clinicians subject to PA requirements based on their performance, adherence to evidence-based medical practices, or participation in value-based agreements.

Regularly review the services and medications that require PA and eliminate requirements for therapies that no longer warrant them.

Improve channels of communications between plans, providers, and patients to minimize care delays and ensure clarity on PA requirements, rationale, and changes.

Protect continuity of care for patients who are on an ongoing, active treatment or a stable treatment regimen when changes in coverage, plans or PA requirements.

Accelerate industry adoption of national electronic standards for PA and improve transparency of formulary information and coverage restrictions at the point-of-care.
New Medicare Cards

**SOCIAL SECURITY NUMBER REMOVAL INITIATIVE (SSNRI)**

Starting April 2018, CMA will:

- Assign 150 million Medicare Beneficiary Identifier’s in the initial enumeration (60 million active/90 million decease/archived) and each new beneficiary
- Generate a new unique MBI for a Medicare beneficiary whose identity has been compromised
- Medicare claims can use old HICN until Jan. 2020

SEE APPENDIX FOR NEW MEDICARE CARD CHECKLIST
Today’s Security Environment

- Practices have now adopted EHRs (75%+)
- Focus of technology has been on meeting govt reporting requirements (Meaningful Use/QPP), not on HIPAA Security
- Wannacry/Petya/Allscripts attacks make front page news
- **Orangeworm** targeting MRI & X-ray machines
- Patients increasingly worried about losing their sensitive information

SEE APPENDIX FOR MGMA CYBERSECURITY CHECKLIST
## MGMA Advocacy in 2018

### Issues that set the stage

<table>
<thead>
<tr>
<th>Administrative costs in the U.S. healthcare system:</th>
<th>Per year, what practices in four common specialties spend on quality reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300 billion+</td>
<td>785 hours per physician</td>
</tr>
<tr>
<td>15% of all healthcare expenditures</td>
<td>$15.4 billion</td>
</tr>
</tbody>
</table>

- **2016 Health Affairs study of MGMA member practices**

- **2016 Health Affairs study of MGMA member practices**

<table>
<thead>
<tr>
<th>Amount of practices that stated their group was being evaluated on quality measures that were not clinically relevant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
</tr>
</tbody>
</table>

- **2016 Health Affairs study of MGMA member practices**
MGMA Advocacy “Feedback Loop”

- Calls and Meetings with CMS/HHS staff
- Discussions with Congress
- Advocacy statements and letters
- Government Affairs Council (GAC)

- Coalition and consensus building with industry partners
- Calls and Meetings with CMS/HHS staff

- MGMA Healthcare Guiding Principles
- Collaboration with state MGMAs
- Advocacy statements and letters
- Government Affairs Council (GAC)

- Washington Connection
- MGMA Healthcare Guiding Principles

- Washington Update Presentations
- Member-benefit Resources
- Access to GA experts
- Dedicated e-Groups
- Grassroots Advocacy

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MGMA Advocacy at Work for Practices

MGMA Advocacy in 2018

MGMA continuously voices medical group practice opposition to Medicare reimbursement cuts. For 2018, we are focusing on:

- Preserving the in-office ancillary exception under the Stark law
- Stopping the sequester cuts to Medicare
- Medical liability reform
- Making MIPS simpler and more predictable

Regulatory Relief

Reduce excessive federal mandates and one-size-fits all regulations. Support high-quality, cost-effective care delivery.

- Patients over Paperwork initiative with CMS
- Cut the Red Tape summit with HHS
- Medicare Red Tape Relief Project with House W&M committee
- Red Tape Roundtable with House W&M committee

Visit our Contact Congress Portal and lend your voice.

Visit MGMA.com/regrelief to learn more.
Questions?

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MGMA.org

Featuring MGMA Government Affairs sessions:

- Regulatory Relief Forum
- Washington Update
- Health IT Policy Update

Register by Tuesday, Aug. 21 and save $200!
APPENDIX
Quality

50 Points / 50% of Final Score | 12 Month Reporting Period

2018 in Brief

- Report 6 measures on 60% of applicable patient encounters, except CAHPS and CMS Web Interface
  - Measures that do not meet data completeness criteria earn 1 point
- No additional cross-cutting measure requirement
- 12-month reporting period
- Improvement bonus up to 10% of quality score available

Maximize Your Score

- Benchmarks for same measure vary by reporting mechanism
- Limited to one reporting mechanism within the category
- Bonus points for all reported measures even if the measure not counted (up to 10% cap)
- Data completeness thresholds are based on the proportion of applicable patients, not the number of clinicians who report data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin</td>
</tr>
<tr>
<td>23</td>
<td>VTE Prophylaxis (When Indicated in ALL Patients)</td>
</tr>
<tr>
<td>52</td>
<td>COPD: Inhaled Bronchodilator Therapy</td>
</tr>
<tr>
<td>224</td>
<td>Melanoma: Overutilization of Imaging Studies in Melanoma</td>
</tr>
<tr>
<td>262</td>
<td>Image Confirmation of Successful Excision of Image-Localized Breast Lesion</td>
</tr>
<tr>
<td>359</td>
<td>Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for CT Imaging Description</td>
</tr>
</tbody>
</table>
2018 IN BRIEF

- Two cost measures formerly used in Value Modifier:
  - Total cost of care for attributed beneficiaries
  - Medicare spending per beneficiary
- No reporting requirements – administrative claim data
- Performance compared against a 2018 benchmark
- CMS will use average of both measures
- Measures risk adjusted for demographic factors and clinical conditions
### Future Outlook for Cost Performance Category

#### MIPS in 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
</tr>
<tr>
<td>Cost</td>
<td>10%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
</tbody>
</table>

#### MIPS in 2019 and beyond

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>30%</td>
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<tr>
<td>Cost</td>
<td>10, 20, 30%?*</td>
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<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
</tbody>
</table>

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**Incomplete:**

- Episode-based cost measures
- MACRA patient relationship categories
- Improved risk adjustment
- Actionable patient attribution, resource use data

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*Bipartisan Budget Act of 2018 Allows CMS to reweight the cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS*
Improvement Activities

15 POINTS / 15% OF FINAL SCORE | 90 DAY REPORTING PERIOD

2018 IN BRIEF

- No change to:
  - 90-day reporting period
  - Scoring policies,
  - Category weight, or
  - Reporting mechanisms

- Additional activities to choose from

- Report via yes/no attestation in portal by Mar. 31 following performance period

SEVERAL PATHS TO FULL-CREDIT

<table>
<thead>
<tr>
<th>Ex.</th>
<th>Reported Activities</th>
<th>Points Earned</th>
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<tbody>
<tr>
<td>1</td>
<td>H H</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>H M M M M</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>M M M M M</td>
<td>40</td>
</tr>
</tbody>
</table>

H: High-weighted activity: 20 points
M: Medium-weighted activity: 10 points
Advancing Care Information (ACI)

25 POINTS / 25% OF FINAL SCORE | 90 DAY REPORTING PERIOD

2018 IN BRIEF

- No change to 90-day reporting period, category weight, 2014 CEHRT permitted
- ECs/groups can still choose from 2018 transitional measures (modified stage 2 MU) or 2018 measures (stage 3 MU)
- New bonus offered for reporting 2018 measures using 2015 CEHRT
- Technical updates to certain measures; requirements for public health registry measure relaxed
- Previous MU measure-specific exclusions implemented
- More providers qualify for ACI re-weighting or hardship due to “special status”

SPECIAL STATUS

- Non-physician practitioners
- Hospital-based ECs
- Ambulatory Surgical Clinic ECs*
- Non-patient facing ECs & groups
- Those facing a significant hardship
  - MU categories
  - Small practices*
  - De-certified EHR*

* New under 2018 QPP rule

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ACI To-Do List

**Check who’s exempted from ACI**

CMS also finalized measure-specific exclusions for e-Rxing and Health Information Exchange.

**Consider implications of group reporting**

ECs exempted from ACI are included in group score.

Practices with multiple EHR systems or practice sites can still report at the TIN level by adding up measure performance results in the attestation portal.

**Understand how measures are scored**

Base score = all or nothing (50% of ACI or 12.5 overall MIPS points)

Performance measures = each measure scored out of 10 or 20 points based on performance rate; CMS adds up all points earned for reported measures to calculate performance score (50% of ACI or 12.5 overall MIPS points)

**Look for opportunities for bonus points**

Report IAs using CEHRT (10%)

Report to more than one public health registry (5% for each additional registry)

Report 2018 measures using 2015 CEHRT (10%)

Report by March 31
An **Alternative Payment Model (APM)** is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

In the **Advanced APM** track of the Quality Payment Program, you may earn a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs. If you achieve these thresholds, you are excluded from the MIPS reporting requirements and payment adjustment.

If you’re in a specific type of APM called a “**MIPS APM**” and you are not excluded from MIPS, you may be scored using a special APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.
New Medicare Cards

Key Practice Checklist Items

- Conduct Patient Outreach
  - Educate your patients (posters, flyers)
  - Remind patients to protect their new Medicare number and only share it with trusted providers

- Get Ready to Use the New MBI Format
  - Talk/test with your PMS vendor and ensure systems and workflow can accommodate HICNs and MBIs
  - Ask billers about their MBI preparations
  - Ensure access to the MAC portal to obtain a patient’s MBI starting in June 2018

- Access the MGMA New Medicare Card Member Resource
CHECKLIST TO PROTECT YOUR PRACTICE

1. **CONDUCT** a complete HIPAA Security Risk Assessment
2. **KEEP** computer operating systems and antivirus software up-to-date
3. **ENCRYPT** all files and systems that contain patient information
4. **DEPLOY** strong user authentication
5. **ENSURE** that your business associates are protecting your data
6. **REQUIRE** training for all practice staff
7. **INSTRUCT** staff not to open emails/attachments/links from unfamiliar senders
8. **BACK UP** patient data (offsite)
9. **RUN** periodic system tests
10. **CONSIDER** cyber insurance