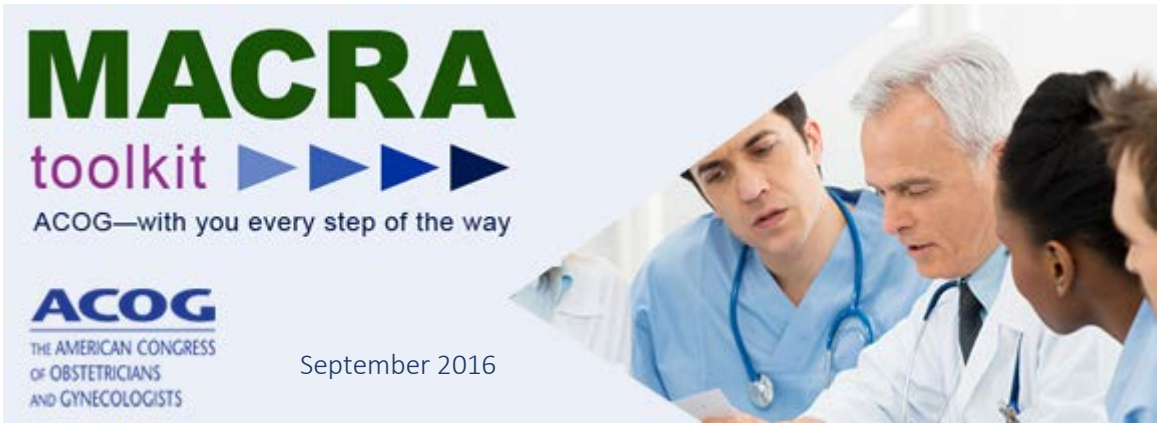


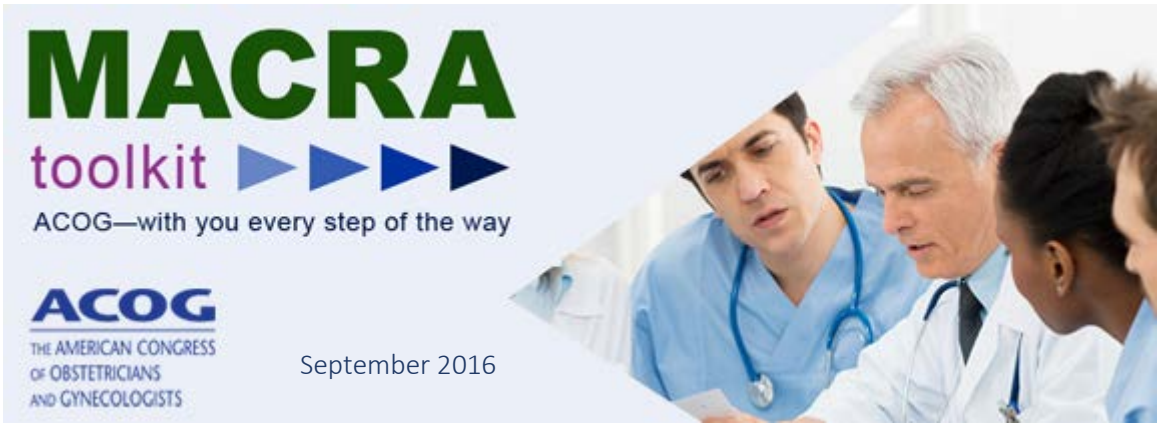
Our reimbursement systems are changing. Payers, including Medicare, are moving away from traditional fee-for-service to value-based care.

We are in the midst of major changes to the way health care is reimbursed. In 2015, the Secretary of Health and Human Services (HHS) announced goals for Medicare and the entire health system to move away from fee-for-service toward value-based care:

- Tying 30 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models (APMs), such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016; 50 percent by the end of 2018.
- Tying 85 percent of traditional Medicare payments to quality or value through programs, such as the Hospital Value-based Purchasing and the Hospital Readmissions Reduction Programs by 2016; 90 percent by 2018.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) furthers these goals by incorporating principles related to value-based care, including ACOs and APMs, into Medicare physician payments.

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who provide coordinated high-quality care to their patients. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it shares in the savings it achieves for the payer.
- Alternative Payment Model (APM) is a general term for payment that is not based solely on fee-for-service.
    - APMs may include episode groups (also referred to as bundled payments), shared savings, or full capitation.
    - APMs typically have some level of financial risk built in. Some models have upside risk, others have downside risk, and some have both (two-sided risk). Upside risk allows physicians to share in savings with no potential for losses, while downside risk places the physician at financial risk for losses.
    - Most APMs also have a quality measurement component.

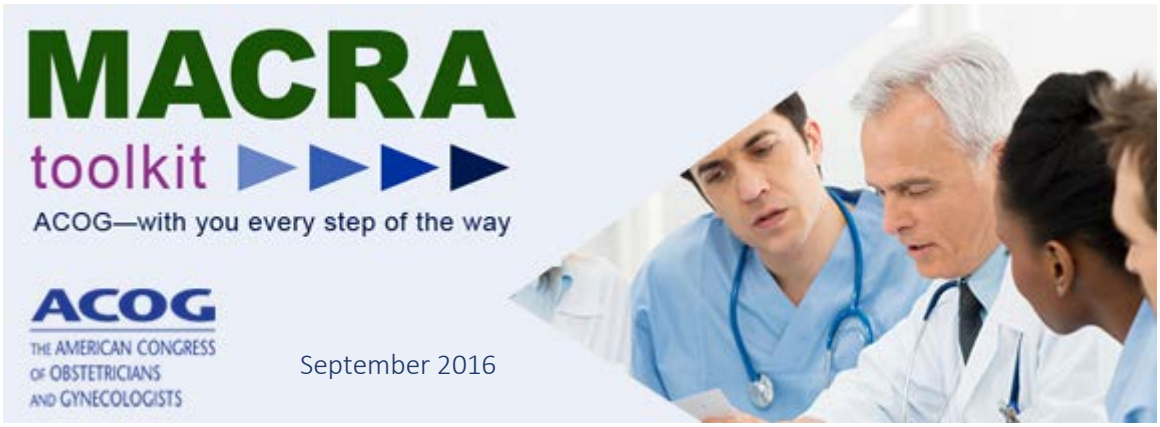


Goodbye, SGR! Hello, MACRA? Welcome to a new Medicare physician payment system under the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program.

For more than a decade, physicians pushed for repeal of the Medicare Sustainable Growth Rate (SGR) formula, a flawed mathematical formula written into law that repeatedly targeted physicians for double-digit cuts. In 2015, a united physician community joined with Congress to finally repeal the SGR, replacing it with a new way of paying physicians under Medicare.

The Basics

- The Quality Payment Program (QPP) is a new way for Medicare to pay physicians for the care you provide based on your performance.
- ACOG estimates that approximately half of all ob-gyns who currently bill Medicare will be exempt from this program.
- You can choose the payment track that works best for you and your patients.
    - The Merit-based Incentive Payment System (MIPS) streamlines 3 existing reporting programs into a single track, adds a new category, and adjusts individual physician's payments based on his or her own performance.
    - Advanced alternative payment models (APMs) requires physicians to accept financial risk in return for bonus rewards.
- MIPS reporting and performance categories are:
    - Quality, similar to the Physician Quality Reporting System (PQRS)
    - Resource Use, similar to the Value Based Modifier (VBM)
    - Clinical Practice Improvement Activities, new
    - Advancing Care Information, similar to Medicare Electronic Health Record (EHR) Incentive Program, also known as Meaningful Use (MU)
- CMS proposes that the first performance year will be calendar year (CY) 2017 and the first payment adjustment period will be CY2019.
- Your MIPS score will determine whether you receive an increase or a cut to your Medicare Part B payments. In the first payment period, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent but may be higher.
- You may be able to report through claims, registries, Qualified Clinical Data Registries (QCDRs), and health information technology developers.



ACOG… With You Every Step of the Way

ACOG is working to ensure this new payment system works for you and your patients and fully reflects the unique practice needs of ob-gyns. We're developing educational materials to help you adapt and succeed. Check back regularly at www.acog.org/macra for new resources. You can also visit the Centers for Medicare and Medicaid Services' website at https://goo.gl/riVixR. Email your questions to practicemanagement@acog.org.

Over the next months, you can count on ACOG to be with you every step of the way:

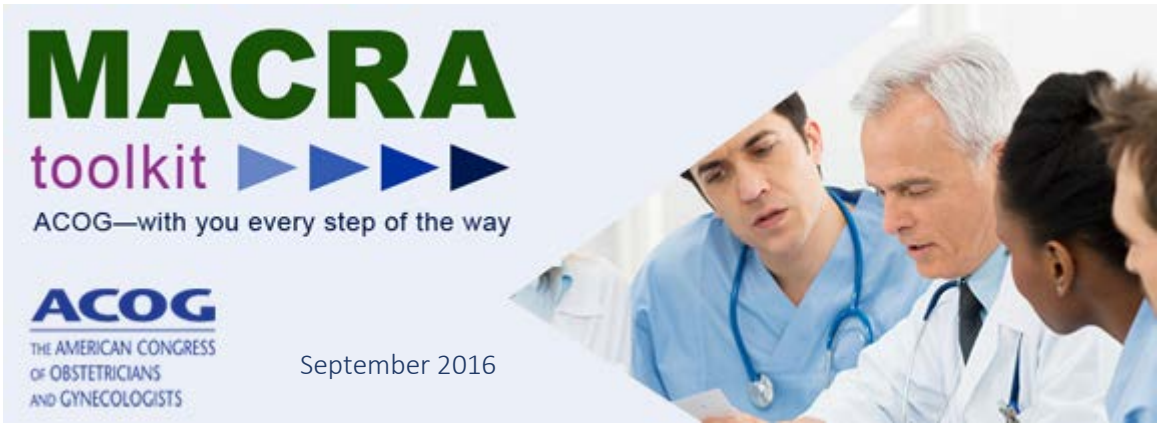
September – We'll report online on a list of quality measures that may be relevant to your practice, along with suggestions on how to succeed under other performance categories. We'll also have MACRA information at the ADMs.

October – We'll improve and tailor our tools to your needs, incorporating your suggestions and concerns at the ADMs. We want to be sure you're ready and understand the final version of the Quality Payment Program.

November and beyond – ACOG will provide new online resources once the Quality Payment Program's requirements are final to help you understand the new rules of the road, and choose your practice path wisely.

ACOG will help you with this important transition with a dedicated webpage, ready-to-use PowerPoints, payment reform modules during Coding Workshops, presentations at ACOG's CLC and Annual Meeting, on-demand webinars, and more.

ACOG… With you every step of the way.



As many as 50% of ob-gyns may be exempt from MACRA. Most other ob-gyns will likely participate in the MIPS program. Familiarize yourself now with MIPS and start thinking about how you can position your practice to ensure success.

Quality Performance Category

The quality performance category adopts many of the same requirements as the Physician Quality Reporting System (PQRS) with some added flexibility. The quality category accounts for 50 percent of your MIPS score in the first year. For this category, you will choose 6 measures to report that best reflect your practice. When choosing your 6 quality measures, you'll choose one cross-cutting measure and one outcome measure (if available) or another high-priority quality measure. High-priority quality measures are related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination.

Physicians will not have to report on population measures. Instead, CMS will calculate two population measures for individual physicians and small groups (2-9 clinicians), and three measures for groups with 10 or more clinicians.

Resource Use Performance Category

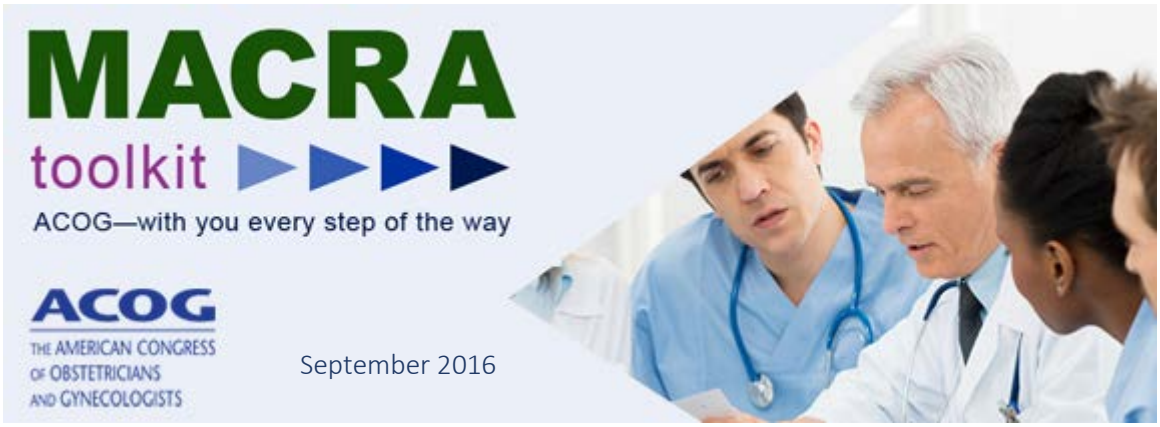
This category is based on the Value-based Payment Modifier (VBM) program, but incorporates new episode-based cost measures. This category accounts for 10 percent of your MIPS score in the first year. Your score will be automatically calculated based on your Medicare claims; you don't have any reporting or other requirements to receive your score.

Each measure will be worth up to 10 points. You'll need to see a sufficient number of patients in each cost measure to be scored, generally a minimum of a 20-patient sample. Your performance category score will be based on the average score of all the cost measures attributed to you.

Clinical Practice Improvement Activities Performance Category

This is a brand new category that rewards practices for implementing activities focused on care coordination, patient engagement, and patient safety. In the first year, this category will make up 15 percent of your MIPS score.

Ob-gyns have more than 90 activities from which to choose. You can receive credit toward this category by participating in alternative payment models (APMs) or a Patient-Centered Medical Home (PCMH). APMs do not have to meet the same standard as an Advanced APM to get credit under this performance



category. Physicians participating in an accredited PCMH will get full credit under this category and do not have to report on any other activities.

Advancing Care Information Performance Category

The advancing care information performance category is based on the Medicare Electronic Health Record (EHR) Incentive Program, also called Meaningful Use. In the first year, this category accounts for 25 percent of your MIPS score. You'll be required to use certified EHR technology and report a set of measures that reflects how you use EHR technology in your daily practice. Your score will be a combination of your base and performance scores.

Base Score

The base score accounts for up to 50 points of the total Advancing Care Information score, and requires you to provide the numerator/denominator or yes/no for each objective and measure. CMS is proposing 6 objectives and associated measures:

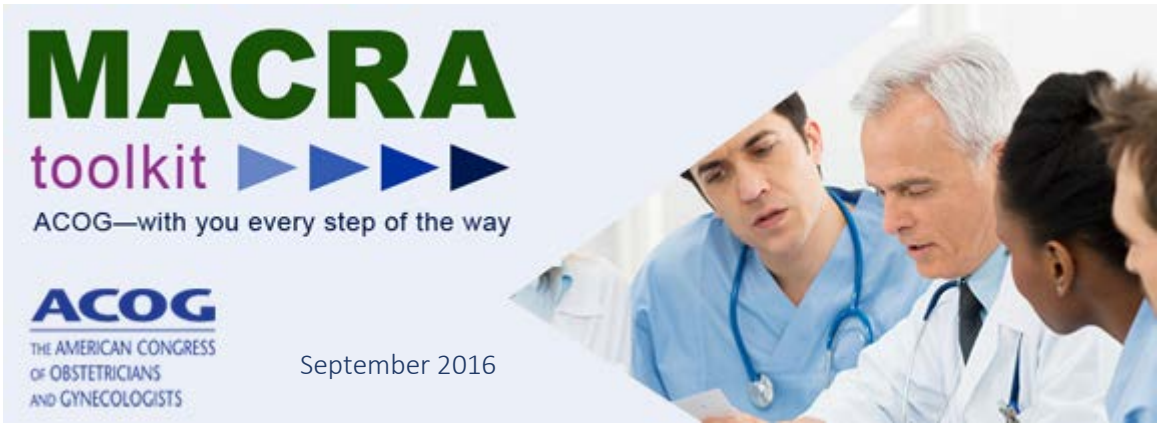
- Protect patient health information
- Patient electronic access
- Coordination of care through patient engagement
- Electronic prescribing
- Health information exchange
- Public health and clinical data registry reporting, specifically immunization registry reporting

Performance Score

The performance score accounts for up to 80 points towards the total Advancing Care Information score. You'll select the measures that best fit your practice from these objectives, which emphasize patient care and information access:

- Patient electronic access
- Coordination of care through patient engagement
- Health information exchange

You may choose to report on more than one public health registry, and will receive one additional point for reporting beyond the required immunization registry reporting. If you earn combined points of 100 or more, you'll receive a perfect score in the advancing care information category.



MACRA Checklist: Prepare Your Practice NOW

CMS has proposed that physicians should start reporting under MIPS and Advanced APMs on January 1, 2017. It's a good idea to take steps now to make your transition as seamless and as successful as possible. Be on the lookout for announcements and new educational materials about changes from ACOG in the coming months.

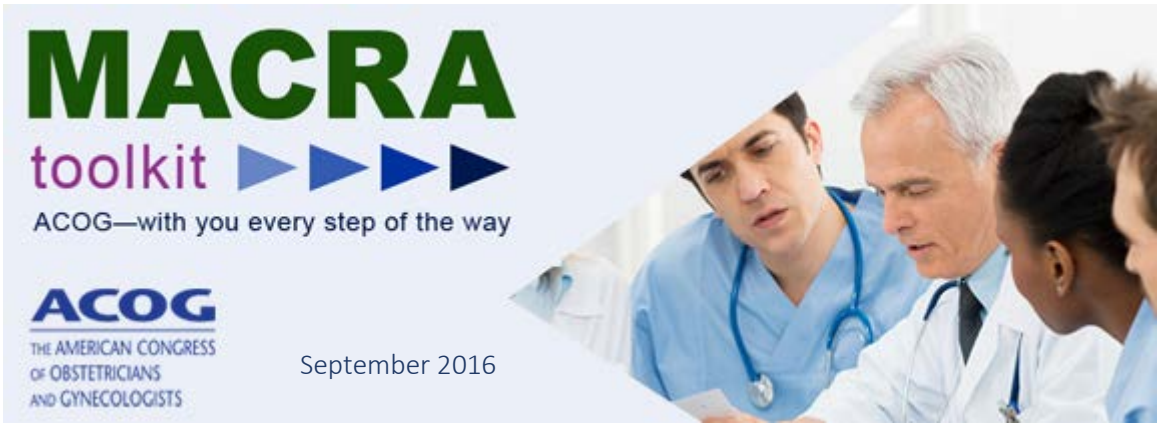
Pick Your Pace

CMS has proposed 4 reporting options during the first performance period in 2017 in order to ensure that the Quality Payment System is successful for as many physicians as possible. Choosing one of these options will ensure that you do not receive penalties during the first payment period.

- ❒ **Option 1**: You can submit some data to the Quality Payment Program, even if it is after January 1, 2017, in order to avoid negative payment adjustments in MIPS.
- ❒ **Option 2**: You can choose to submit data for a reduced number of days, rather than the full year. If you select this option, you may receive a small positive payment adjustment.
- ❒ **Option 3**: For practices that are ready to go on January 1, 2017, you can opt to submit data for the entire year-long performance period. If you select this option, you may receive a modest positive payment adjustment.
- ❒ **Option 4**: Instead of reporting through MIPS, you can participate in an Advanced APM. If your practice sees enough Medicare patients or receives enough Medicare payments through the Advanced APM during the performance period, you can receive a 5 percent bonus.

Important Considerations

- ❒ Determine whether you'll likely meet the low-volume threshold and be exempt from reporting. If you **saw ≤100 patients and have ≤$10,000 in submitted Medicare Part B charges**, you will likely be exempt. **ACOG estimates that 50% of ob-gyns who bill Medicare will meet the low-volume threshold, and ACOG is working to set the threshold higher to make it easier for ob-gyns to meet.**
  - Exempt physicians will receive a 0.5% payment increase to the fee schedule in 2019, no payment adjustments from 2020 to 2025, and annual fee increases of 0.25% in 2026 and beyond.
- ❒ Decide whether to report as an individual or as a group.
  - Reporting as a group may limit your ability to report on relevant quality measures if you are in a multispecialty practice.



- Reporting as a group may also be complicated if there are multiple electronic health record (EHR) systems used by practices sharing the same tax identification number (TIN.)

❒ Carefully examine how the infrastructure and staff costs required for MIPS reporting compare to your greatest potential payment cut in each performance year: 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and beyond.

❒ Determine whether your practice meets the requirements for small or rural physician accommodations. Learn more about the available accommodations at https://goo.gl/L2g01B.

❒ If you are a urogynecologist, consider participating in the AUGS registry. Data registries can streamline reporting and give you a better MIPS score.

MIPS Quality Measurement

❒ Determine which quality measures best reflect your practice from an ob-gyn-specific measure set.

❒ Consider which reporting method works best for you: claims, your EHR, clinical registry, qualified clinical data registry (QCDR), or group practice reporting option web interface. The web interface is available for practices with 25 or more clinicians.

❒ If you participate in the Physician Quality Reporting System (PQRS), check your feedback reports. Make sure you understand your current quality metrics reporting requirements and how you are scoring across PQRS and private payers. Many of the existing rules for PQRS will be rolled into MIPS.

❒ Access and review your 2014 annual PQRS feedback reports to see where you can make improvements. The reports are available on the CMS Enterprise Portal using an Enterprise Identity Data Management account.

MIPS Resource Use

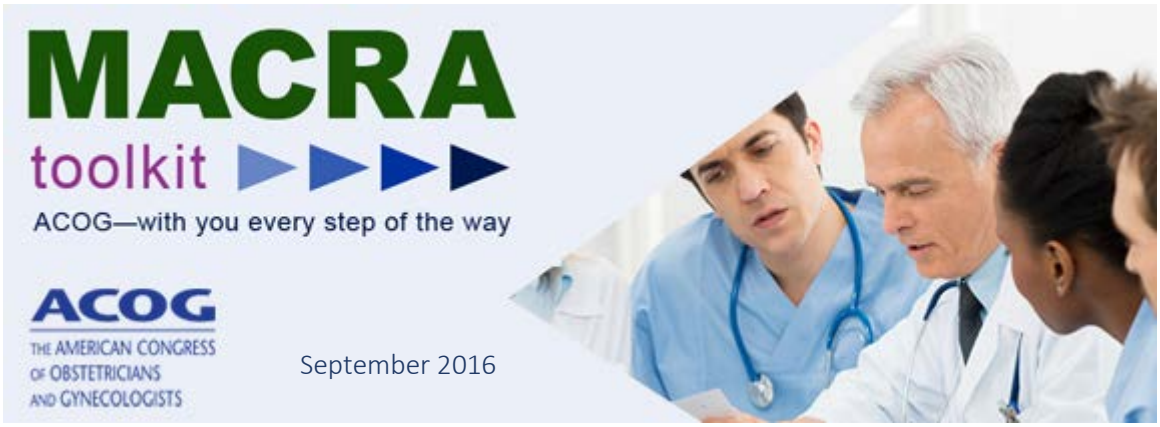
❒ Identify your most costly patient population's conditions and diagnoses.

❒ Identify targeted care delivery plans for these conditions.

❒ Identify internal workflow changes that can better support care delivery plans.

❒ Identify potential partners outside of your practice, such as specialists for referrals, to advance a coordinated care plan.

❒ If you participate in the Value-based Payment Modifier (VBM) program, check your Medicare quality and resource use reports (QRURs) to see where you can improve your performance.



MIP Clinical Practice Improvement Activities

- ❒ Review the proposed list of activities to evaluate what activities your practice is already doing and what you can implement in 2017.
- ❒ Consider which 90-day period in 2017 would work best for your practice's selected activities since this performance category has a 90-day reporting period.
- ❒ If you participate in a nationally-recognized, accredited Patient Centered Medical Home (PCMH) or National Committee for Quality Assurance patient-centered specialty medical home, ensure that your certifications and accreditations are up-to-date. Physicians participating in medical homes can receive full credit under this performance category.

MIPS Advancing Care Information

- ❒ If you have an electronic health record (EHR), make sure that it is certified EHR technology (CERHT). Determine whether it is 2014- or 2015-edition CEHRT so you know which measures you must report on.
- ❒ Make sure you are able to report at least one unique patient (or answer "yes," as applicable) for each of the six objectives in the performance category's base score. For example:
    - Encourage your patients to use your patient portal to view, download, and transmit their health information in 2017.
    - Send out appointment reminders through your EHR to all of your patients in 2017 if your system supports secure messaging.
- ❒ Conduct a security risk analysis early in 2017 that is compliant with the HIPAA Security Rule requirements.
- ❒ Determine if you can report to an additional public health registry to receive a bonus point in this performance category.
- ❒ Talk with your vendor about how your EHR supports adoption of new payment models, such as Medicare quality reporting, and document these conversations.

Alternative Payment Models

- ❒ Confirm whether you participate in an Advanced APM.
- ❒ If you believe that you are participating in an Advanced APM, determine whether you are likely to meet the threshold for significant participation to qualify for bonus payments.
- ❒ Determine whether 50 percent of the clinicians in the Advanced APM use CEHRT.