Navigating Medicare’s Quality Payment Program: 
MIPS Advancing Care Information and Improvement Activities Categories

Physicians Advocacy Institute
MACRA Educational Series
April 2017
About the Physicians Advocacy Institute

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.
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Guide to the PAI MACRA Educational Series

• **Overall purpose** – Program of materials and resources that provide context, an overview of core concepts and requirements, and an in-depth discussion of important topics

• **MACRA overview** – Foundational presentation and associated webinars to include a focus on meeting requirements for the 2017 transition period. Includes different sections on aspects of MACRA’s Quality Payment Program.

• **Follow-on products in early 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting

• **In development** – Guide to additional resources in physician communities
Acronyms

• ACI – Advancing Care Information Category
• APMs – Alternative Payment Models
• CEHRT – Certified EHR Technology
• EHR/EMR – Electronic Health Registry; Electronic Medical Record
• MACRA – Medicare Access and CHIP Reauthorization Act
• MIPS – Merit-Based Incentive Payment System
• PQ – Partially Qualifying Advanced APM Participant
• QCDR – Qualified Clinical Data Registry
• QP - Qualifying Advanced APM Participant
• QPP – Quality Payment Program
What to find in this presentation . . .

1) **Merit-Based Incentive Payment System (MIPS) Overview** (slide 8)
   - Participation Eligibility and Exemptions (slide 9)
   - MIPS Performance Category Overview (slide 12)
   - Reporting Options (slide 13)

2) **2017 Transition Year Minimum Reporting Options** (slide 15)

3) **MIPS Advancing Care Information (ACI) Category** (slide 18)
   - ACI Scoring (slide 20)
   - ACI Measures and Objectives (slide 21)
   - ACI Bonus for Reporting Improving Activities via CEHRT (slide 23)
   - ACI Exemptions (slide 25)

4) **MIPS Improvement Activities Category** (slide 26)
   - Improvement Activities Scoring (slide 28)
   - Improvement Activities for Small, Rural, HPSA, and non-patient-facing physicians (slide 29)

5) **Reporting Timeline** (slide 32)

6) **Next steps and Looking Forward** (slide 33)
Merit-based Incentive Payment System (MIPS) Overview
Who does QPP affect and who is required to participate in MIPS?

• The program will eventually include almost all clinicians who bill for Medicare Part B services; this will be phased in over time

• “Eligible Clinicians” subject to MIPS in 2017:
  • Physicians
    • Physician means doctor of: medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and, with respect to certain specified treatment, doctor of chiropractic legally authorized to practice by a State in which he/she performs this function
  • Physician Assistants
  • Nurse Practitioners
  • Clinical Nurse Specialists
  • Certified Registered Nurse Anesthetists

• “Eligible Clinicians” may be expanded in 2019 to also include:
  • Physical or occupational therapists
  • Speech language pathologists
  • Audiologists
  • Nurse midwives
  • Clinical social workers
  • Clinical psychologists
  • Dieticians or nutrition professionals
Some eligible clinicians are exempt from MIPS...

**Exempted from MIPS**

- Newly-enrolled Medicare physicians, who enroll in Medicare for the first time during the performance year
- Physicians and groups that are below the low-volume threshold:
  - Who have Medicare Part B allowed charges $\leq$ $30,000$
  - Who provide care to 100 or fewer Medicare Part B patients
- Physicians who are participating in Advanced APMs

**CMS estimates** - CMS estimates that 32.5% of eligible clinicians will be exempt from MIPS in 2017 because of the low-volume threshold

CMS will make available an NPI-level lookup tool on its QPP website later this year to assist physicians and other clinicians in determining if they are below the low-volume threshold, and therefore excluded from MIPS participation in 2017

- Practice Tip: Physicians should keep a record of the eligibility/exemption status provided by CMS
Participation options for physicians

- Physicians can participate either as individuals or as a group, but they must participate the same way across all four categories.

- As an individual
  - Physicians would report under an NPI number and the tax identification number (TIN) of the practice to which they reassign their benefits.

- As a group
  - 2 or more physicians (2 or more NPIs) who are part of the same practice with the same TIN.
  - Specific reporting requirements and certain reporting options are available for groups of 25 or more physicians.
  - All physicians in the group would receive the same aggregated scoring and corresponding payment adjustment across the group.

- Additionally, all physicians in a practice must participate the same way – either individually, or as a group.
  - For example, in a practice of 10 physicians all under the same TIN, the practice can elect to participate at the group level (the group of 10 physicians would collectively have to meet the specific requirements for each category) or decide that each of the 10 physicians would report as individual physicians (each physician would have to meet the specific requirements for each category).
MIPS performance categories - overview

**Quality**
- Builds off Physician Quality Reporting System
- Report 6 measures, including 1 outcomes measure or a specialty-specific measures set
- Primary factor early on -- **60% of score** for 2019 payment adjustment

**Cost**
- Builds off Value-based Modifier
- New cost measures being developed for 2018
- No data reported; CMS uses administrative claims data to assess performance
- Implementation eased as costs are **0% of score** for 2019 payment adjustment

**Advancing Care Information**
- Builds off Meaningful Use and encourages greater use of health information technology
- Report required 4 or 5 measures for base score
- **25% of score** for 2019 payment adjustment
- Challenging area for many physicians

**Improvement Activities**
- New category
- Rewarding engagement in clinical practice improvement activities
- Report any combination of high and medium weight activities to achieve 40 total points
- **15% of score** for 2019 payment adjustment
# Reporting mechanisms and options

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Activities &amp; Advancing Care Information</strong></td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td></td>
<td>Attestation, QCDR, Qualified Registry, EHR</td>
</tr>
<tr>
<td></td>
<td><strong>Group</strong></td>
</tr>
<tr>
<td></td>
<td>Attestation, QCDR, Qualified Registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)</td>
</tr>
</tbody>
</table>
## Selecting the best option...

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Pros/Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation</td>
<td>No submission of data is required; another affordable option</td>
</tr>
<tr>
<td></td>
<td>Must keep records for audit purposes</td>
</tr>
<tr>
<td>QCDR/Qualified Registry</td>
<td>These can be specialty-specific and offer more applicable quality measures; but also may be more limited in scope</td>
</tr>
<tr>
<td></td>
<td>Physicians must pay a registration fee and additional fees for data integration services; however, some national specialty societies offer this option at no or low cost to members</td>
</tr>
<tr>
<td></td>
<td>Difficulty linking to EHR systems and automatically extracting the data (often requires manual data entry)</td>
</tr>
<tr>
<td></td>
<td>Requirement for “all-payer data”</td>
</tr>
<tr>
<td>EHR</td>
<td>Many practices already use EHRs in daily practice (but not all practices have access to EHRs)</td>
</tr>
<tr>
<td></td>
<td>Vendor submits the data on your behalf, but you must trust that vendor will correctly and accurately submit the information</td>
</tr>
<tr>
<td></td>
<td>Depending on the measures selected and number of applicable patients, may be more advantageous to use an EHR than a specialized registry</td>
</tr>
<tr>
<td></td>
<td>Limited availability of applicable quality measures that can be reported via an EHR</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>Only for groups of 25 or more physicians and eligible clinicians</td>
</tr>
<tr>
<td></td>
<td>Higher reporting thresholds for Quality measures (must report more measures)</td>
</tr>
<tr>
<td></td>
<td>Must register by June 30, 2017</td>
</tr>
</tbody>
</table>
2017 Transition Year Minimum Reporting Options
2017 “Transition Year” – Opportunities for easy participation

Don’t Participate
• Submit no data
• -4% payment adjustment in 2019

Test – Submit Something
• Submit a minimum amount of data
• Avoid negative payment adjustment

Partial – Submit Partial Year
• Submit 90-days worth of data
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

Full – Submit Full Year
• Submit data for all 2017
• Avoid negative payment adjustment
• Eligible for maximum positive payment adjustment

A negative payment adjustment can be avoided by reporting just a minimum amount of data!
Options for minimal “test” participation in 2017

Submit something – avoid a -4% payment adjustment with a minimum amount of data

Three options:

- Quality – report data for 1 patient for 1 quality measure (can be reported through claims),
  - Practice Tip: It is recommended that additional data (more than 1 patient) be reported for the quality category to better ensure that the penalty is avoided
- OR Improvement Activities – report 1 improvement activity (can be completed through attestation),
- OR Advancing Care Information – report 1 patient for each of the required base measures (4 or 5 based on 2014 or 2015 certified EHR technology)

Other approaches - With both the partial (90-day) and full-year participation options, physicians are eligible to receive the maximum positive payment adjustment for reporting the full requirements for each category, if the number of cases is sufficient to be scored
MIPS Advancing Care Information (ACI)
Category
Advancing Care Information (ACI) category

25% of MIPS final score in 2017

Total points possible = 155 points

However, only 100 points are needed to earn full credit for the ACI category

Reporting Requirement:

• Report all required measures for base score (90-day reporting period)
• Report up to 9 optional measures for additional performance score
• Options for standard and transition measures, using CEHRT 2014 and/or 2015

Reporting Mechanisms:

• Attestation, QCDR, qualified registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)
ACI scoring breakdown . . .

**Base Score**
- 50 Points
  - Report yes/no or numerator/denominator for required base measures (depends on CEHRT edition)
  - All required base measures must be reported to earn any credit in the ACI category
  - Failure to report base measures will result in a score of 0 points for ACI category
  - Performance measures will not be counted if base measures are not reported

**Performance Score**
- Up to 90 points
  - Report up to 7 or 9 performance measures (depends on CEHRT edition)
  - Each performance measure is worth 10-20 points
  - The number of points you would receive for each measure would be determined by your performance rate for each measure
  - You are not required to report all additional performance measures; any performance measures reported in addition to base measures will increase your overall ACI score

**Bonus Points**
- Up to 15 points
  - 5 bonus points can be earned for reporting one or more of the following Public Health and Clinical Data Registry Reporting measures:
    - Syndromic Surveillance Reporting
    - Specialized Registry Reporting
    - Electronic Case Reporting
    - Public Health Registry Reporting
    - Clinical Data Registry Reporting
  - 10 bonus points can be earned for reporting certain Improvement Activities using CEHRT
<table>
<thead>
<tr>
<th>Measure</th>
<th>Required for base score</th>
<th>Performance score weight</th>
<th>Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Registry Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for submitting to one or more public health or clinical data registries</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Electronic Case Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for active engagement with a public health agency to electronically submit case reporting of reportable conditions</td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>Yes</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>No</td>
<td>0 or 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>Yes</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Public Health Registry Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for submitting to one or more public health or clinical data registries</td>
</tr>
<tr>
<td>Request/Accept Summary of Care</td>
<td>Yes</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Security Risk Analysis</td>
<td>Yes</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>Send a Summary of Care</td>
<td>Yes</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Syndromic Surveillance Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for submitting to one or more public health or clinical data registries</td>
</tr>
<tr>
<td>View, Download and Transmit</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
</tbody>
</table>
## 2017 ACI transition measures and objectives

<table>
<thead>
<tr>
<th>Measure</th>
<th>Required for base</th>
<th>Performance Score Weight</th>
<th>Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>Yes</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Yes</td>
<td>Up to 20 points</td>
<td>No</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>No</td>
<td>0 or 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Provide Patient Access</td>
<td>Yes</td>
<td>Up to 20 points</td>
<td>No</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
<tr>
<td>Security Risk Analysis</td>
<td>Yes</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>Specialized Registry Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for submitting to one or more public health or clinical data registries</td>
</tr>
<tr>
<td>Syndromic Surveillance Reporting</td>
<td>No</td>
<td>0</td>
<td>5 bonus points for submitting to one or more public health or clinical data registries</td>
</tr>
<tr>
<td>View, Download and Transmit</td>
<td>No</td>
<td>Up to 10 points</td>
<td>No</td>
</tr>
</tbody>
</table>
Report Improvement Activities via CEHRT and earn ACI bonus – High weight activities

- Provide 24/7 access to eligible clinicians or groups who have real-time access to patient’s medical record
- Anticoagulant management improvement
- Glycemic management services
Report Improvement Activities via CEHRT and earn ACI bonus – Medium weight activities

Medium weight improvement activities

- Chronic care and preventive care management for empaneled patients
- Implementation of methodologies for improvements in longitudinal care management for high risk patients
- Implementation of episodic care management practice improvements
- Implementation of medication management practice improvements
- Implementation or use of specialist reports back to referring clinician or group to close referral loop
- Implementation of documentation of improvements for practice/process improvements
- Implementation of practices/processes for developing regular individual care plans
- Practice improvements for bilateral exchange of patient information
- Use of certified EHR to capture patient reported outcomes
- Engagement of patients through implementation of improvements in patient portal
- Engagement of patients, family and caregivers in developing a plan of care
- Use of decision support and standardized treatment protocols
- Leveraging a QCDR to standardize processes for screening
- Implementation of integrated primary care and behavioral health (PCBH) model
- Electronic health record enhancements for behavioral health (BH) data capture
Exemption from ACI reporting

• The ACI category can be reweighted to 0% of the final score in some cases
• The 25% ACI weight would be assigned to the quality performance category

Physicians can submit an application for reweighting for one of the following hardships
• Insufficient internet connectivity
• Extreme and uncontrollable circumstances
• Lack of control over the availability of CEHRT

The following physicians qualify for automatic reweighting to 0% (however, they may report and be scored for ACI)
• Hospital-based eligible physicians
• Physicians assistants
• Nurse practitioners
• Clinical nurse specialists
• Certified registered nurse anesthetists
• Physicians who lack face-to-face interaction with patients
MIPS Improvement Activities Category
Improvement Activities category

15% of MIPS final score in 2017
Total possible points = 40 points
New category; no previous program

Reporting:
- High-weight activities: worth 20 points each
- Medium-weight activities: worth 10 points each
- 90-day reporting period

Reporting Mechanisms:
- Attestation, QCDR, qualified registry, EHR, CMS Web Interface (groups of 25 or more eligible clinicians)
Improvement Activities category scoring

Score:

- Any combination of high and medium weight activities equaling at least 40 total points
  - 2 high-weight activities (2 x 20 = 40 points)
  - 4 medium-weight activities (4 x 10 = 40 points)
  - 2 medium-weight activities AND 1 high-weight activity ((2 x 10) + (1 x 20) = 40 points)

- Using CEHRT to report a clinical practice improvement activity can earn bonus points towards the ACI category score
Improvement Activities category – small, rural, HPSA, and non-patient facing practices

15% of MIPS final score in 2017
Total possible points = 40 points

Eligibility:
- Solo physicians
- Groups with 15 or fewer physicians and other eligible clinicians
- Physicians in rural or health professional shortage areas (HPSAs)
- Non-patient facing physicians

Reporting – alternative scoring weights:
- High-weight activities: worth 40 points each
- Medium-weight activities: worth 20 points each
- 90-day reporting period

Reporting Mechanisms:
- Attestation, QCDR, qualified registry, EHR
Improvement Activities category – scoring for small, rural, HPSA, and non-patient facing practices

Score:

- Any combination of high and medium weight activities equaling at least 40 total points:
  - 2 medium-weight activities (2 x 20 = 40 points)
  - 1 high-weight activity (1 x 40 = 40 points)

- Using CEHRT to report can earn bonus for ACI score

Total points earned

Maximum points available (40 points)

Improvement Activities Score (15% of final score in 2017)
MIPS - Improvement Activities categories

- Physicians may select from 92 clinical practice improvement activities
- List of improvement activities and activities search tool are available on CMS’s website: https://qpp.cms.gov/measures/ia

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Sample Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving Health Equity</td>
<td>Leveraging a QCDR for use of standard questionnaires</td>
</tr>
<tr>
<td>Behavioral and Mental Health</td>
<td>Depression screening; diabetes screening</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Engagement of patients, family and caregivers in developing a plan of care</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Care transition documentation practice improvements</td>
</tr>
<tr>
<td>Emergency Response &amp; Preparedness</td>
<td>Participation on disaster medical assistance team, registered for 6 months</td>
</tr>
<tr>
<td>Expanded Practice Access</td>
<td>Use of telehealth services to expand practice access</td>
</tr>
<tr>
<td>Patient Safety &amp; Practice Assessment</td>
<td>Implementation of fall screening and assessment programs</td>
</tr>
<tr>
<td>Population Management</td>
<td>Engagement of community and health status improvement</td>
</tr>
</tbody>
</table>

NOTE: You are not required to perform activities in each subcategory in order to receive the highest possible score.
### Performance to payment timeline – submission and CMS dates for 2017 performance year

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance period began</td>
<td>Jan. 1, 2017</td>
</tr>
<tr>
<td>Registration deadline for CMS Web Interface and CAHPS</td>
<td>March/Spring 2017</td>
</tr>
<tr>
<td>Last day to begin 90-day reporting period</td>
<td>Aug. 31, 2017</td>
</tr>
<tr>
<td>Last day 2017 claims processed for 2019 adjustment</td>
<td>Oct. 2, 2017</td>
</tr>
<tr>
<td>End of performance period</td>
<td>Dec. 31, 2017</td>
</tr>
<tr>
<td>Last day 2017 claims processed for 2019 adjustment</td>
<td>Late Feb. 2018</td>
</tr>
<tr>
<td>CMS applies adjustment based on 2017 performance</td>
<td>March 31, 2018</td>
</tr>
<tr>
<td>CMS feedback reports on 2017 performance and targeted review period to appeal errors</td>
<td>Fall 2018</td>
</tr>
<tr>
<td>CMS applies adjustment based on 2017 performance</td>
<td>Jan. 2019</td>
</tr>
</tbody>
</table>

- CMS publishes 2017 qualified registries and QCDRs
- Performance period began
- Registration deadline for CMS Web Interface and CAHPS
- Last day to begin 90-day reporting period
- Last day 2017 claims processed for 2019 adjustment
- End of performance period
- CMS feedback reports on 2017 performance and targeted review period to appeal errors
- CMS applies adjustment based on 2017 performance
Next steps and looking forward
Next Steps: Should I select the MIPS pathway?

• Determine whether you are exempt from MIPS participation

• Pick your quality reporting pace for 2017 by evaluating practice readiness
  • Determine if participating for a minimum of 90 days and becoming eligible to receive a positive payment adjustment is feasible for you/your practice

• Select the best reporting mechanism(s) by evaluating practice resources
  • Is a specialty-, diagnosis-, or treatment-specific QCDR with more applicable measures available?
  • What new processes and workflows will need to be put in place to meet the reporting requirements?
  • Do you have access to an EHR?

• Consider whether the Advanced APM option is feasible before making the final decision
Next Steps: I am participating in an Advanced APM

If you are participating in an Advanced APM:

• CMS will make 3 evaluations in 2017 to determine whether physicians meet QP/PQ thresholds
  • The determination periods are March 31 (decision by July 2017), June 30 (decision by October 31), and August 31 (decision by December 31)

• Check these determinations to see if you have meet the QP/PQ thresholds and are exempt from MIPS

• If you meet the QP thresholds, you are exempt from MIPS participation

• If you meet the PQ thresholds, then the APM Entity you are part of could elect to participate in the MIPS APM option
What PAI-Healthsperien resources will be available to help?

• **Follow-on products in 2017** – In-depth one-pagers and monographs focused on topics such as the MIPS scoring system and strategies for reporting and how to meet the minimum reporting requirements for 2017

• **In development** – Guide to additional resources in physician communities

• **FAQ document** – updated on a continuous and ongoing basis with important questions

• **Regular e-mail updates** – E-mails will provide updates on new information, materials, and tools available from PAI, Healthsperien, as well as CMS and other organizations
www.PhysiciansAdvocacyInstitute.org