The Evolution of Practice Transformation: Getting Ready for Alternative Payment Models

Judith Steinberg, MD, MPH
Deputy Chief Medical Officer
Commonwealth Medicine
UMass Medical School
Agenda

• Overview: Health Care Reform
• MA Health Care Reform
• CMS Payment Reform
• Transforming Clinical Practices Initiative
• Conclusions
• Discussion
Why Reform: US Overall Ranking

<table>
<thead>
<tr>
<th>Overall Ranking (2013)</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>5</td>
</tr>
<tr>
<td>Effective Care</td>
<td>3</td>
</tr>
<tr>
<td>Safe Care</td>
<td>7</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>6</td>
</tr>
<tr>
<td>Patient Centered Care</td>
<td>4</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>9</td>
</tr>
<tr>
<td>Cost Related Problem</td>
<td>11</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>5</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>11</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>11</td>
</tr>
<tr>
<td>Health Expenditures /Capita, 2011</td>
<td>$8,508</td>
</tr>
</tbody>
</table>
Health Care Reform: The Affordable Care Act

Integrated, Coordinated, Accountable Care & Value-Based Payments

• Advancing:
  – Medical home pilots
  – Medicaid health homes for patients with chronic diseases
  – Accountable Care Organizations
  – Value based payment models

• Improving care coordination – community health teams

• Promoting Health IT

• Promoting quality measurements

• Scaling up if medical home and ACO pilots reduce cost
Continuum of Payment Methods: Moving to Value Based Payments

- Fee-for-Service (FFS)
- FFS and Care Management Fee
- Bundled Payments
- Global Payments
Incentivizing Value

• Pay for Performance
  – Clinical quality
  – Efficiency
  – Patient Experience

• Shared Savings
  – With quality gates and/or quality performance modifiers
# Patient Centered Medical Home Joint Principles: Then and Now

<table>
<thead>
<tr>
<th>2007 Original</th>
<th>2014 Integrating Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal physician</td>
<td>Home of the team</td>
</tr>
<tr>
<td>Whole person orientation</td>
<td>Requires BH service as part of care</td>
</tr>
<tr>
<td>Care coordinated</td>
<td>Shared problem &amp; medication lists</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>Requires BH on team</td>
</tr>
<tr>
<td>Enhanced access</td>
<td>Includes BH for patient, family &amp; provider</td>
</tr>
<tr>
<td>Appropriate payment</td>
<td>Funding pooled &amp; flexible</td>
</tr>
</tbody>
</table>

- [http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf](http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf)
- *Ann Fam Med* 2014; 183-185; Joint Principles from AAFP, ABFM, STFM
- Slide adapted from Sandy Blount
## PCMH Payment Mechanisms

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vermont Blueprint for Health Integrated Medical Home</td>
<td>• $1.20-$2.39 pmpm based on NCQA PCMH tier</td>
</tr>
<tr>
<td></td>
<td>• Payers share cost of Community Care teams</td>
</tr>
<tr>
<td></td>
<td>• HIE provided</td>
</tr>
<tr>
<td>CTC-Rhode Island (Multi-payer)</td>
<td>• $5.50 pmpm base with up to $8.75 pmpm for P4P on quality, patient experience &amp; efficiency measures</td>
</tr>
<tr>
<td>Minnesota Health Care Homes</td>
<td>• <strong>Risk adjusted care coordination pmpm:</strong> average $31.39 pmpm</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>• <strong>MA PCMHI:</strong> $3 pmpm and shared savings</td>
</tr>
<tr>
<td></td>
<td>• <strong>PCPR:</strong> Risk adjusted primary care and behavioral health global payment: $35 – $58 pmpm, P4P, shared savings</td>
</tr>
</tbody>
</table>
PCMH Evidence Base: Summary

• 2016 Patient Centered Primary Care Collaborative (PCPCC) report:
  – 30 studies, 17 peer reviewed: “largely positive and consistent trends on cost and utilization measures” and improvements in quality
  – Impressive results: Vermont Blue Print for Health, Community Care North Carolina, Colorado Multi-payer PCMH, Geisinger PCMH, Colorado ACC

• Key points:
  – Studies vary by: size, scope, geography, target population, payment model, definition of PCMH, implementation approach, duration of evaluation
  – Transformation takes time: the longer the PCMH implemented and evaluated, better results
  – “No single payment system stood out as definitive” Many successful PCMHs utilized innovative payment models that shifted from volume to value
  – Need for longer duration studies, linkage to patient and provider experience and health outcomes, total cost of care and ROI analysis

The Patient Centered Medical Home’s Impact on Cost and Quality, PCPCC, Feb, 2016
Accountable Care Organizations

• Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.
• Payments linked to quality improvements that also reduce overall costs.
• Reliable and progressively more sophisticated performance measurement

Accountable Care Organizations

- Medicare ACOs
  - Medicare Shared Savings
  - Pioneer ACOs
  - Next Generation ACOs

- Medicaid ACOs

- Commercial Payer Alternative Payment Model Contracting

- Accountable Health Communities
  - Washington
  - Minnesota
  - Vermont
Total Public and Private Accountable Care Organizations, 2011 to 2015 Q4

Medicaid ACOs: Challenges

- Understanding how to deploy population health analytics to improve care
- Integrating behavioral health
- Integrating long-term services and supports
- Addressing dual eligibles
MA Statewide Health Care Reform Initiatives

**Reform Timeline**

- **2009**: Safety Net Medical Home
- **2010**: CHIPRA Medical Home
- **2011**: One Care
- **2012**: MassHealth ACO (In design phase)
- **2013**: PCMH Certification
- **2014**: Primary Care Payment Reform
- **2015**: Health Homes (In design phase)
- **2016**: ACO Certification (In design phase)
Massachusetts Patient-Centered Medical Home Initiative

- Multi-payer, statewide initiative
- Sponsored by MA Health & Human Services, legislatively mandated
- 44 participating practices
- 3-year demonstration; March 2011 – March 2014
- Included payment reform and a formal evaluation

Vision: All MA primary care practices will be PCMHs by 2015
Clinical Quality Measures: Significant Improvement in Change over Time

11/22 measures showed statistically significant improvement
MA PCMHI Qualitative Evaluation: 5 Factors Contributing to Transformation

- Sequence of core competency adoption
- Strong leadership and staff buy-in
- Focus on staff capacity and resources
- Electronic Medical Record (EMR) proficiency
- Active use of available technical assistance and peer learning
Sequencing: Build the Home from the Foundation Up

- Care Coordination
- Clinical Care Management
- Clinic System Integration

- Multi-Disciplinary Care Team
- Evidenced-based, Pro-active care delivery
- Patient-centeredness

- Leadership Engagement
- Data-Driven Quality Improvement
- Patient Involvement in Transformation
Implement Care Integration in each PCMH Component
MassHealth Primary Care Payment Reform

MassHealth’s alternative payment program that will enable MassHealth to move from fee-for-service reimbursement towards alternative payment models.

• Goals:
  – To improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health
  – Increase accountability for the total cost of care

• Start: March 2014

• As of March 2015: 20 participating practice organizations, 63 sites
MassHealth Primary Care Payment Reform

**Comprehensive Primary Care Payment**
- Risk-adjusted capitated payment for primary care services
- **3 Tiers of payment:**
  - 1 - PCMH, 2 - PCBH, 3 - SPMH

**Quality Improvement Payment**
- Annual incentive for quality performance, based on primary care performance

**Shared Savings Payment**
- Primary care providers share in savings on non-primary care spend, including hospital and specialist services
MA Behavioral Health Integration: The Landscape

MA Health Policy Commission
- CHART program
- PCMH & Accountable care certification programs
- Substance use services access and capacity evaluation

MassHealth
- Primary Care Payment Reform
- One Care
- MassHealth Accountable Care Organizations
- Health homes
- Enhanced risk adjustment models

MA Health and Human Services
- Capacity assessment of MA behavioral health care system
- Opioid epidemic taskforce and legislation

CMS
- Medicare Shared Savings, Pioneer and Next Gen ACOs
- Transforming Clinical Practices Initiative
MassHealth Payment Reform: Risk Adjustment

• Investigating use of risk adjustment models that include:
  – Indicators of social determinants of health
    ✓ Homelessness
    ✓ Census tract data
  – Comprehensive behavioral health and long term services and supports data
A MassHealth ACO models: 3 types of ACO models

Model A: Integrated ACO/MCO model
- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

Model B: Direct to ACO model
- ACO provider contracts directly with MassHealth for overall cost/quality
- Based on MassHealth/MBHP provider network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

Model C: MCO-administered ACO model
- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk

Increasing levels of sophistication, care coordination, and DSRIP $s
CMS Payment Reform

• By 2018, 50% of Medicare payments will use alternative payment models
• Fee-for-service is going away
  – Where it persists, it will be tied to value or quality
• A premium on controlling costs
• All roads lead to ACOs?
• Many clinicians and health care organizations are not ready
HHS Sets the Stage for Change

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

New targets have been set for value-based payment: 85% of Medicare fee-for-service payments should be tied to quality or value by 2016, and 30% of Medicare payments should be tied to quality or value through alternative payment models by 2016 (50% by 2018).

TCPI was listed as a specific strategy to improve care delivery in the U.S.

U.S. Dept. of Health and Human Services Secretary Sylvia M. Burwell Three Strategies to Drive Progress:

1. Incentives to reward high-quality health care
2. Improving the way care is delivered
3. Accelerate availability of information to guide decision making

Slide from COMPASS PTN
HHS Sets Value-Based Payment Goals

Target Percentage of Payments in FFS Linked to Quality and Alternative Payment Models by 2016 and 2018

2016

- 30% All Medicare FFS (Categories 1-4)
- 85% FFS linked to quality (Categories 2-4)

2018

- 50% All Medicare FFS (Categories 1-4)
- 90% FFS linked to quality (Categories 2-4)

GOALS:

Slide from Compass PTN
MACRA, SGR and MIPS

Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
• Signed in to law April 2015 with bipartisan support
• Permanently repeals the 1997 Sustainable Growth Rate (SGR) Physician Fee Schedule (PFS) Update
• Changes Medicare PFS Payments

• MACRA: Must Choose Between Two Value-Based Payment Tracks:
  1. Merit-Based Incentive Payment System (MIPS)
  2. Alternative Payment Models (APM)
Merit-Based Incentive Payment System (MIPS)

Effective Date of January 1, 2019
  • Performance measurement begins January 1, 2017

Features of PQRS, the Value Modifier (VM) and the EHR Meaningful Use program are included in MIPS

Clinicians will be evaluated using a scoring system from 0 to 100
  • Score will be used to determine and apply a MIPS payment adjustment factor for 2019 onward
  • Adjustment can be positive, negative or zero
  • Budget neutral program
Alternative Payment Models (APM)

For 6 years, physicians who meet threshold participation levels are eligible for lump sum bonuses of 5%

- 5% is on top of the regular payment updates for all physician services
- 5% is also on top of any extra revenue the physician receives from the APM, such as savings achieved or monthly per-patient payments

Beginning in 2026, physicians in APMs receive annual payment updates of 0.75% whereas other physicians receive payment updates of 0.25%

Examples of APM

- A Center for Medicare and Medicaid Innovation (CMMI) Model
- A Medicare Shared Savings Program
- Accountable Care Organizations (ACO)
- Other similar CMS demonstration models (i.e., Bundled Payment)
CMS Transforming Clinical Practice Initiative and

The Southern New England Practice Transformation Network (SNE-PTN)
Transforming Clinical Practices Initiative (TCPI): Aims

1. Transform Practice
   Support more than 140,000 clinicians in work practice transformation

2. High Performance
   Improve health outcomes for 5M Medicare, Medicaid & CHIP beneficiaries

3. Reduce Utilization
   Reduce unnecessary hospitalizations & over utilization of other services for 5M Medicare, Medicaid & CHIP beneficiaries

4. Scale
   Build the evidence base on practice transformation so that effective solutions can be scaled, if successful

5. Savings
   $1 - $4B in savings to the federal government over 4 years through reduced Medicare, Medicaid & CHIP expenditures

6. Value Based
   Move clinicians through the TCPI phases to participate in incentive programs & practice models the reward value
CMS TCPI Funds

• 29 Practice Transformation Networks (PTNs)
  – State and regional hubs for TA, shared learning, practical resources for practice transformation

• 10 Sustaining and Alignment Networks (SANs)
  – National Associations that support recruitment of clinicians in PTNs
  – Spread and institutionalize PTN learnings
  – Offer additional benefits to member-participants (APA, ACP, ACEP, AMA)

• National faculty and shared learning
• Website as a communication hub
• Data aggregation and reporting
• Likely a national evaluator
Practice Transformation Networks (PTN)

Peer-based learning networks designed to support clinicians providing:

- Coaching/Mentoring
- Assistance in the development of core competencies specific to practice transformation

No financial cost for participants
TCPI Eligible Clinicians

- Bill under an NPI
- Not participating in a Medicare shared savings ACO

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic
- Clinical Pharmacist
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologists
- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist
- Certified Registered Nurse Anesthetist
- Certified Nurse Midwife
Southern New England PTN focus: The Quadruple Aim

1. Better patient experience
2. Better population health
3. Lower costs
4. Better work-life for clinicians and staff

SNE-PTN geographical focus areas: MA and CT
SNE-PTN Vision

• Create a **community of learning** utilizing cross-functional teams to share best practices, align efforts and resources

• Innovate and address the need to bring back the **joy** in practicing medicine

• Foster **continuous quality improvement** for patients, families and providers

• Create **cost savings** through efficiencies of scale to prepare for alternative payment models

• Facilitate **data-driven improvement** in clinical care, patient experience and operational efficiency
Southern New England Practice Transformation Network – The Value Proposition

Achieve the Quadruple Aim and Bring Joy Back to Your Clinical Practice!

**Succeed in Value-Based Payment**
- Optimize current revenue
- Prepare for alternative payment models

**Optimize Use of Health Information Technology**
- Calculate and report clinical quality measures
- Give clinicians actionable care gap information

**Strengthen Connections to Community Partners**
- Improve coordination across primary and specialty care, hospitals, behavioral health and community-based providers

**Free Technical Assistance**
- Quality Improvement Advisors
- Faculty Experts
- Professional Resources – CMEs, etc.

---

University of Massachusetts Medical School
umassmed.edu
Building The Medical Neighborhood
SNE-PTN Approach

Customized and *Practice*-centered:

- Help practices articulate *their* transformation agenda
- Prioritize efforts
- Identify measures
- Facilitate transformation through data-driven QI
Transformation Support Intervention

Clinicians will:
- Create and coordinate local medical neighborhoods
- Implement and sustain practice transformation
- Reduce unnecessary hospitalizations
- Improve clinical and operational measures
- Achieve financial success

SNE-PTN Clinicians will:

Transformation Toolbox: Implementation
- Technical assistance
- Faculty experts
- Useful resources
- Sharing best practices
- Data optimization
- Patient engagement

Clinical Recruitment
Quality Improvement Advisor Assigned
Practice Readiness Assessment
Practice Transformation Plan Development
Practice Transformation

Clinical Recruitment
Quality Improvement Advisor Assigned
Practice Readiness Assessment
Practice Transformation Plan Development
Practice Transformation

Clinical Recruitment
Quality Improvement Advisor Assigned
Practice Readiness Assessment
Practice Transformation Plan Development
Practice Transformation
1. 75% of TCPI Clinicians will be prepared for alternative payment models

2. Create and coordinate local medical neighborhoods

3. TCPI Clinicians will achieve practice transformation

4. Reduce Medicaid, Medicare, CHIP growth rates

5. Reduce unnecessary hospitalizations

6. Clinical and operational measures demonstrate improvement

Clinical Intervention for QI

- Implement quality improvement methods and use data for learning and improving
- Facilitate care transitions
- Enhance internal and external communication
- Use EHR and QI

Person Centered Care

- Treat person and family as equal partners in care
- Share information and make it easy to access
- Respond to person issues
- Include persons in quality improvement activities
- Include persons and families in improvement work

Data and Measurement

- Use data for QI
- Use data to measure improvement
- Prepare to share data for new payment systems

Engaged Leadership

- Use data transparently
- Recruit and engage clinicians
- Set the direction and maintain interest in TCPI
- Plan for sustainability and spread
- Align policy and procedure

Medical Neighborhood and Community Resources

- Link persons to medical neighborhood and community resources
- Create support systems in medical neighborhood and community resources
- Build knowledge of community resources in practice

Outcomes

Primary Drivers

Secondary Drivers
Performance Measures

- **Diabetes** HbA1c > 9%
- **Diabetes**: BP < 140/90 mmHg
- **Heart failure**: advanced care plan
- **Readmission rate** following heart failure hospitalization
- **Appropriate use of medications** for asthma
- **Use of imaging studies** for low back pain
- **Use of high-risk medications** in the elderly
- **Fall risk** screening
- **Depression screening**
- **Hospital-wide all-cause unplanned readmission measure**
- **Prevention quality indicator composite**

**Likely additional measures**: pediatrics, specialty care, patient experience
Our Partners, Collaborators, and Stakeholders

**University of Massachusetts Medical School**
Practice Transformation Network Lead

**University of Connecticut School of Medicine**
Sub Awardee

**Clinical Partners**
- Baycare Health Partners
- Berkshire Health Systems
- UMMHC
- UConn Health Center

**QIOs**
- Healthcentric Advisors
- Qualidigm

**Intervention Partners**
- MA Health Policy Commission
- Qualis Health
- MA League of Community Health Centers
- Center for Primary Care/Harvard Medical School

**IT Partners**
- SMC Partners
  - (ehealthCT)
- Massachusetts eHealth Institute (MEHI)

**Stakeholders and Collaborators**
- MA & CT Medicaid, SIM
- MA & CT Depts of Public Health
- Growing List!
Southern New England Practice Transformation Network – Key Contacts

David Polakoff, MD, Msc
Director, Center for Health Policy and Research
Chief Medical Officer and Associate Dean
Email: David.Polakoff@umassmed.edu
Phone: 508.856.6737

Judith Steinberg, MD, MPH
Deputy Chief Medical Officer
Email: Judith.Steinberg@umassmed.edu
Phone: 508-856-3196

Ronald (Ron) Adler, MD, FAAFP
Physician Lead, Recruitment and Engagement
Email: Ronald.Adler@umassmed.edu
Phone: 508-856-4877

Valerie Konar, MBA, MEd
TCPI PTN Project Manager
Email: Valerie.Konar@umassmed.edu
Phone: 508-856-4079
Conclusions

• Health Care Reform emphasizes integrated, coordinated and accountable care with value-based payments
• MA health care reform provides many lessons learned in implementation of new care delivery and payment models
• CMS is moving to 100% value based payments by 2019
• Evaluations of new care delivery and payment models are challenging – the verdict is out
• Payment reform is necessary but not sufficient to make change: Providers need new skillsets, additional workforce and TA to effectively implement new models
• TCPI and the SNE-PTN provides free TA to providers to help them implement new models and be successful under value based payments
Path to the Triple AIM?
Discussion
Extra slides
Medicare Shared Savings Program:
Year 1 (2013) Performance of 220 Participating ACOs

- 24% (52 ACOs) earned shared savings bonus
- 3% (6 ACOs) achieved savings, but did not successfully report quality measures
- 27% (60 ACOs) reduced spending, but not enough to earn shared-savings bonus
- 46% (102 ACOs) did not achieve savings

MassHealth ACO models: how does the payment model work?

- ACOs have total cost of care accountability for the following areas:
  - All managed care eligible spend (physical health + behavioral health)
  - LTSS: Year 1 reporting only; Year 2 and on some accountability phases in
  - At this time, HCBS waiver services continue to be provided outside of ACO scope and budgets
  - Total cost of care is risk-adjusted (UMass Medical School is developing a risk adjustment model that incorporates some of the social determinants of health)
  - Separate “rating category” or adjustor for Serious Mental Illness (SMI)

- Who is paying claims
  - Model A: the MCO that is part of the integrated ACO/MCO entity
  - Model B: MassHealth and MBHP pay claims to providers in the MassHealth and MBHP network
  - Model C: MCOs pay claims to providers in their networks
  - ACOs are not responsible for paying claims and authorizing LTSS services (exceptions in future years, if the ACO is integrated with an MCO qualified to cover LTSS)

- Payments for ACOs are linked to performance on quality metrics across multiple domains
  - We will also measure quality and access of care specifically for members with disabilities (e.g., for ID/DD members, individuals with physical disabilities)

- In addition, we will increase member protections to ensure right care from the right providers
  - Members in ACO models will have access to an ombudsman and advocacy resource
  - Members with LTSS needs in ACO models will be able to access an LTSS Community Partner (CP – see later in document for detail) as an independent advocate and resource counselor
Medicare Payments Increasingly Tied to Value

Percentage of Medicare FFS Tied to Quality and Value

- **2016 (Goal):** 85%
- **2018 (Goal):** 90%

Percentage of Medicare Payments Linked to Quality and Value via APMs

- **2016 (Goal):** 30%
- **2018 (Goal):** 50%

---


# MIPS Payment Adjustment Schedule

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunset of existing penalties PQRS, VBM, EHR 12/31/2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Repeal of SGR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Updates in Physician Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5% (7/2015-2019)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0% (2020-2025)</td>
<td></td>
<td>0.25% (2026)</td>
</tr>
<tr>
<td>Merit-based Incentive Payment System (MIPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of MIPS 2019 Measurement Cycle</td>
<td>+/-4%</td>
<td>+/-5%</td>
<td>+/-7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIPS exceptional performance adjustment: Up to 10% annually (2019-2026)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Relative Weights of MIPS Components

<table>
<thead>
<tr>
<th>Component</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (PQRS)</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>MU*</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical Process Improvement</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Reward/Risk</td>
<td>+4% to -4%</td>
<td>+5% to -5%</td>
<td>+7% to -7%</td>
<td>+9% to -9%</td>
</tr>
</tbody>
</table>

* MU weight may be reduced to 15% if 75% of Eps are successful