CMS Priorities, MACRA and The Quality Payment Program

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Presentation on behalf of HSAG
November 16, 2016
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Objectives

• Overview of CMS Priorities
  - Shifting from Volume to Value-Based payments
  - Program alignment and streamlining

• Health System Transformation: MACRA 2015
  - Review of the Medicare Access and CHIP Reauthorization Act
  - The Quality Payment Program Final Rule

• Key updates and resources
  - Options for participation in 2017
  - Opportunities for technical support
Complications

[Image: A Surgeon's Notes on an Imperfect Science]

The ‘Must Do’ List: Certain Patient Safety Rules Should Not Be Elective

Robert Wachter
August 20, 2015

So we will continue to work across sectors and across the aisle for the goals we share: better care, smarter spending, and healthier people.
# Better Care, Smarter Spending, Healthier People

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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</table>
| Incentives         | - Promote value-based payment systems  
                      - Test new alternative payment models  
                      - Increase linkage of Medicaid, Medicare FFS, and other payments to value  
                      - Bring proven payment models to scale  |
| Care Delivery      | - Encourage the integration and coordination of services  
                      - Improve population health  
                      - Promote patient engagement through shared decision making  |
| Information        | - Create transparency on cost and quality information  
                      - Bring electronic health information to the point of care for meaningful use  |

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
# Ongoing work of The CMS Innovation Center

## Focus Areas

### Pay Providers

**Test and expand alternative payment models**
- **Accountable Care**
  - Pioneer ACO Model
  - *Medicare Shared Savings Program* (housed in Center for Medicare)
  - Advance Payment ACO Model
  - *Comprehensive ERSD Care Initiative*
  - *Next Generation ACO*

- **Primary Care Transformation**
  - *Comprehensive Primary Care* Initiative (CPC)
  - Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
  - Independence at Home Demonstration
  - Graduate Nurse Education Demonstration
  - *Home Health Value Based Purchasing* (proposed)

- **Bundled payment models**
  - *Bundled Payment for Care Improvement Models 1-4*
  - *Oncology Care Model*
  - Comprehensive Care for Joint Replacement (proposed)

- **Initiatives Focused on the Medicaid population**
  - Medicaid Emergency Psychiatric Demonstration
  - Medicaid Incentives for Prevention of Chronic Diseases
  - Strong Start Initiative
  - *Medicaid Innovation Accelerator* Program

- **Dual Eligible (Medicare-Medicaid Enrollees)**
  - Financial Alignment Initiative
  - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

- **Other**
  - Medicare Care Choices
  - *Medicare Advantage Value-Based Insurance Design* model

### Deliver Care

**Support providers and states to improve the delivery of care**
- **Learning and Diffusion**
  - Partnership for Patients
  - Transforming Clinical Practice
  - Community-Based Care Transitions

- **Health Care Innovation Awards**

### Distribute Information

**Increase information available for effective informed decision-making by consumers and providers**
- Information to providers in CMMI models
- Shared decision-making required by many models
Collaboration with National Partners
Measure Alignment Efforts

• CMS Quality Measure Development Plan
  - Highlight known measurement gaps and develop strategy to address these
  - Promote harmonization and alignment across programs, care settings, and payers
  - Assist in prioritizing development and refinement of measures
  - Public Comment period closed March 1\textsuperscript{st}, final report published May 2\textsuperscript{nd}

• Core Measures Sets released February 16\textsuperscript{th}
  - ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics

CMS Health Equity Plan for Medicare

**Priority 1:** Expand the Collection, Reporting, and Analysis of **Standardized Data**

**Priority 2:** Evaluate **Disparities Impacts** and Integrate Equity Solutions Across CMS Programs

**Priority 3:** Develop and Disseminate **Promising Approaches** to Reduce Health Disparities

**Priority 4:** Increase the Ability of the **Health Care Workforce** to Meet the Needs of Vulnerable Populations

**Priority 5:** Improve **Communication & Language Access** for Individuals with LEP & Persons with Disabilities

**Priority 6:** Increase **Physical Accessibility** of Health Care Facilities
Key CMS Priorities in health system transformation

3 goals for our health care system:

- BETTER care
- SMARTER spending
- HEALTHIER people

Via a focus on 3 areas:

- Incentives
- Care Delivery
- Information Sharing

Affordable Care Act → MACRA
Origins of the Quality Payment Program: MACRA


- Increases focus on quality of care delivered
  - Clear intent that outcomes needed to be rewarded, not number of services
  - Shifts payments away from number of services to overall work of clinicians

- Moving toward patient-centric health care system

- Replaces Sustainable Growth Rate (SGR)
Medicare Payments Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.
MACRA changes how Medicare pays clinicians.

- The Quality Payment Program policy will **reform Medicare Part B payments** for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
Quality Payment Program

QUALITY PAYMENT PROGRAM

Modernizing Medicare to provide better care and smarter spending for a healthier America.

https://qpp.cms.gov
How Does the Quality Payment Program Benefit Clinicians and Patients?

**Clinicians**

- **Streamlines** reporting
- Standardizes measures (evidence-based)
- **Eliminates duplicative reporting**, which allows clinicians to spend more time with patients
- Promotes **industry alignment** through multi-payer models
- Incentivizes care that focuses on improved **quality outcomes**

**Patients**

- Increases access to better care
- **Enhances coordination** through a patient-centered approach
- Improves results
Which clinicians does MACRA affect?
(Will it affect me?)
Who participates in the Quality Payment Program?

- Medicare Part B eligible clinicians who:
  - Bill more $30,000 a year in Medicare charges AND
  - Provide care for more than 100 Medicare Part B patients in a given year

- Eligible clinicians:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
The Quality Payment Program has two tracks you can choose from:

Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

The Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
One Path to Quality:

The Merit-based Incentive Payment System (MIPS)
What Is MIPS?

Combines legacy programs into single, improved reporting program

Legacy Program Phase Out

2016

Last Performance Period under Legacy Programs

2018

End of Payment Adjustments under Legacy Programs
Take note:

• Changes under MACRA related to the Quality Payment Program do **not** affect the Medicaid OR Hospital EHR Incentive program

• Clinicians attesting under these programs should continue to do so based on that program time frame and schedule
What Is MIPS?

Performance Categories:

- Reporting standards align with Alternative Payment Models when possible
- Many measures align with those being used by private insurers

Clinicians will be reimbursed under Medicare Part B based on this Performance Score

https://qpp.cms.gov
Performance Score Category Weighting

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

NOTE: These are defaults weights; the weights can adjust in certain circumstances
How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive +/- or neutral adjustments **up to** the percentages below:

- **2017**: ± 4%
- **2018**: ± 5%
- **2019**: ± 7%
- **2020**: ± 9%
- **2021**: ± 9%
- **2022**: ± 9%

The potential **maximum** adjustment % will **increase** each year from **2019** to **2022**.
How Do Clinicians Participate in MIPS?

1. **Individual**: under an NPI number & TIN where they reassign benefits

2. **As a Group**:
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As a MIPS APM entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS categories
When Will Clinicians Learn If They Are Eligible for MIPS?

December 2016

CMS contacts clinicians

January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal
The Timeline for the Quality Payment Program

When does the Quality Payment Program start?

You get to pick your pace for the Quality Payment Program. If you're ready, you can begin January 1, 2017 and start collecting your performance data. If you're not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

https://qpp.cms.gov
Pick Your Pace during the Transitional Year

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

<table>
<thead>
<tr>
<th>Test Pace</th>
<th>Partial Year</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit Something</td>
<td>Submit a Partial Year</td>
<td>Submit a Full Year</td>
</tr>
<tr>
<td>• Submit <strong>some</strong> data after January 1, 2017</td>
<td>• Report for 90-day period after January 1, 2017</td>
<td>• Fully participate starting January 1, 2017</td>
</tr>
<tr>
<td>• Neutral or small payment adjustment</td>
<td>• Small positive payment adjustment</td>
<td>• Modest positive payment adjustment</td>
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Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.
Choosing to Test for 2017

• Submit a minimum amount of 2017 data to Medicare
  - 1 Quality Measure
    (timeframe and amount of data based on measure specifications)
  OR
  - 1 Improvement Activity
    (timeframe and amount of data based on measure specifications)
  OR
  - 5 required Advancing Care Information Measures

• If you test, you can avoid a reimbursement penalty in 2019
Partial Participation for 2017

• Submit 90 days of 2017 data to Medicare
  - More than 1 Quality Measure,
  - More than 1 Improvement Activity, or
  - More than the 5 required Advancing Care Information measures

• You may earn a neutral or small positive payment adjustment

• If you’re not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017

• Send in performance data by March 31, 2018
**Full Participation for 2017**

- Submit a full year of 2017 data to Medicare
- You may earn a moderate positive payment adjustment
- To earn the largest positive adjustment is to participate fully in the program by submitting information in all the MIPS performance categories.

**Key Takeaway:**

Payment adjustments are based on the performance data submitted, not the amount of information or length of time submitted.
Who is excluded from MIPS?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.

- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients

- **Clinicians significantly participating in Advanced APMs**
Another Path to Quality:

Advanced Alternative Payment Models (APMs)
Alternative Payment Models (APMs)

A payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care.

APMs can apply to a specific clinical condition, a care episode, or a population.
Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes.
Advanced APMs in 2017

For the 2017 performance year, the following models are Advanced APMs:

| Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements) | Comprehensive Primary Care Plus (CPC+) |
| Shared Savings Program Track 2 | Shared Savings Program Track 3 |
| Next Generation ACO Model | Oncology Care Model (Two-Sided Risk Arrangement) |

The list of Advanced APMs is posted at HTTPS://QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.
Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

- **In future performance years**, we anticipate that the following models will be Advanced APMs:
  - Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
  - New Voluntary Bundled Payment Model
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
  - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
  - ACO Track 1+
Participation in “MIPS APMs”

- Shared Savings Program Tracks 1, 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
The Quality Payment Program

The Quality Payment Program has two tracks you can choose from:

**Advanced Alternative Payment Models (APMs)**

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

**The Merit-based Incentive Payment System (MIPS)**

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
Note: Most clinicians will start in the MIPS pathway

Subject to MIPS

Not in APM

In non-advanced APM

In advanced APM, but not a QP

QP in advanced APM

Some people may be in advanced APMs and but not have enough payments or patients through the APM to be a QP.

Note: Figure not to scale.
Easier Access for Small Practices

Small practices will be able to successfully participate in the Quality Payment Program

Why?

- Reducing the time and cost to participate
- Providing an on-ramp to participating through Pick Your Pace
- Increasing the opportunities to participate in Advanced APMs
- Conducting technical support and outreach to small practices through the forthcoming QPP Small, Rural and Underserved Support Program as well as through the Transforming Clinical Practice Initiative.
Small, Rural and Health Professional Shortage Areas (HPSAs) Exceptions

• Established low-volume threshold excludes a clinician if they:
  - Bill $30,000 or less in Medicare Part B allowed charges OR see 100 or fewer Medicare patients in a given year

• Reduced requirements for Improvement Activities performance category
  - One high-weighted activity OR Two medium-weighted activities

• Increased ability for clinicians practicing at Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers to qualify as a Qualifying APM Participant (QP).
NEXT STEPS

What do I need to do now?
When Will Clinicians Learn If They Are Eligible for MIPS?

December 2016

CMS contacts clinicians

January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal
MIPS Overview

Use this tool to browse the different MIPS measures and activities.

Note: This tool is only for informational and estimation purposes. You cannot use it to submit or attest to measures or activities.

Quality Measures

Instructions
1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You cannot use it to submit or attest to measures or activities.

Select Measures

Showing 271 Measures

- Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use
- Acute Otitis Externa (AOE): Topical Therapy
- ADHDs: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

https://qpp.cms.gov
Quality Payment Program: How to get help

<table>
<thead>
<tr>
<th>Need Help</th>
<th>Questions</th>
</tr>
</thead>
</table>
| The Quality Payment Program Service Center is available to help.  
1-866-288-8912  
TTY: 1-877-715-6222  
Available Monday-Friday; 8:00AM – 8:00PM Eastern Time | Send us your questions about the Quality Payment Program to QPP@cms.hhs.gov |

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ashby.wolfe1@cms.hhs.gov
What Support Is Available to Clinicians?

Integrated Technical Assistance Program

- Full-service, expert help
  - Quality Payment Program Service Center
  - Quality Innovation Network/Quality Improvement Organizations
  - Quality Payment Program — Small, Underserved, and Rural Support
  - Transforming Clinical Practice Initiative
  - APM Learning Networks

- Self-service
  - QPP Online Portal

All support is FREE to clinicians

https://qpp.cms.gov/education
Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

[Locate the PTN(s) and SAN(s) in your state](#)

**SMALL & SOLO PRACTICES**
Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - Organizations selected to provide this technical assistance will be available in late 2016.

**LARGE PRACTICES**
Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

[Locate the QIN-QIO that serves your state](#)

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website:** [qpp.cms.gov](http://qpp.cms.gov)
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  Assists with all Quality Payment Program questions.
  1-866-289-8292  TTY: 1-877-715-6222  [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)

- **Advanced Alternative Payment Model (APM) Learning Networks**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.
NEXT STEPS

Where can I go to learn more?
Quality Payment Program: Upcoming learning opportunities

- Medicare Access and CHIP Reauthorization Act of 2015 Final Rule
  - Wednesday, October 26, 2016
  - 2:00 - 3:00 PM Eastern Time

- Quality Payment Program Final Rule MLN Connects
  - Tuesday, November 15, 2016
  - 1:30 - 3:00 PM Eastern Time

Additional webinars planned!

https://qpp.cms.gov/education
CMS wants your feedback!

**Public Inspection:** October 19, 2016

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**Comment Period Closes:** December 19, 2016.

https://qpp.cms.gov
Questions?

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