CMS Update:

Policies to Support Care of the Complex Patient

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Presentation to the Best Practices & GPRA Measures Conference

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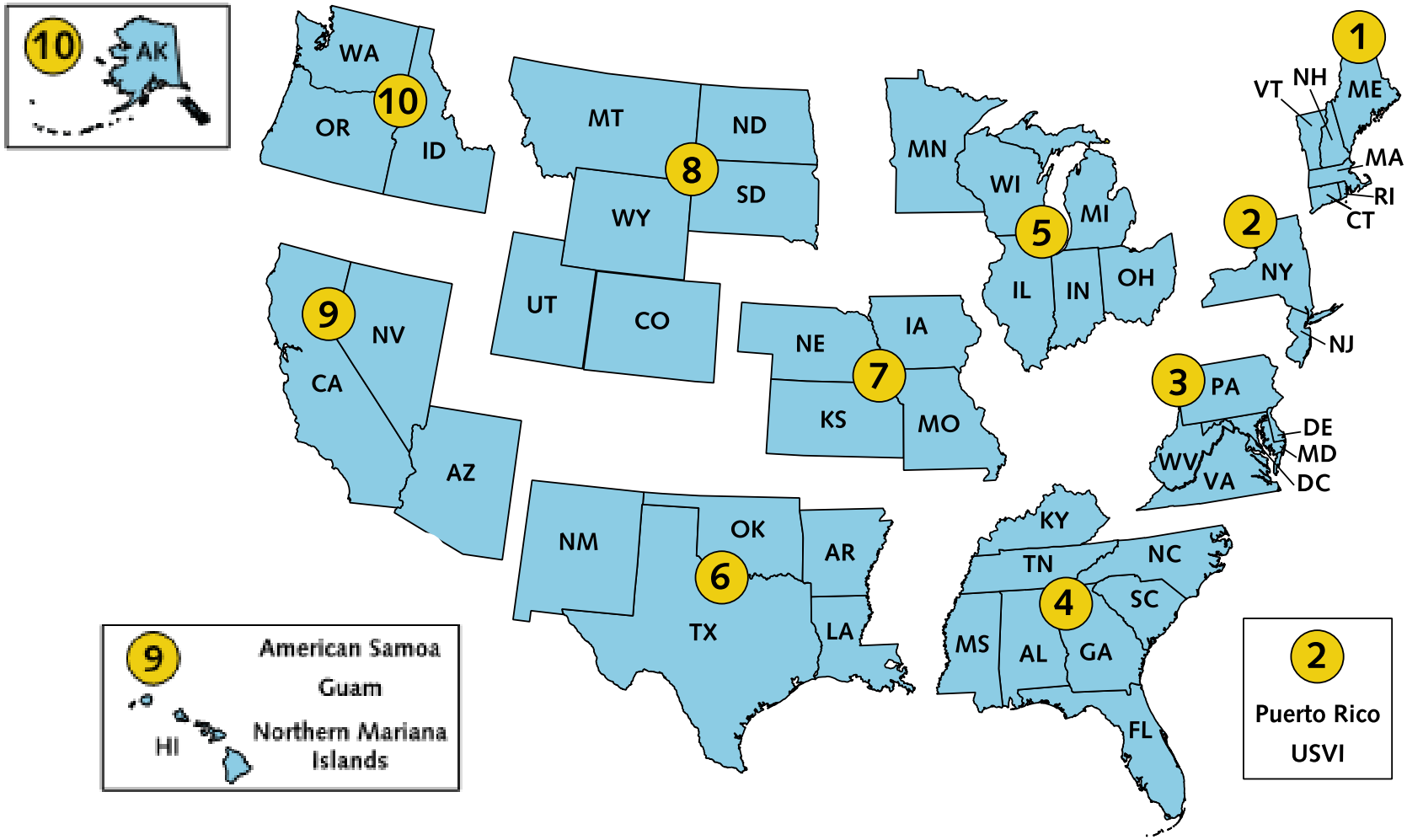
Objectives for today

- **Update: Million Hearts Initiative**
  - Collaboration with HRSA through the Health Center Program
  - Cardiac Rehabilitation
- **Overview of current CMS Priorities**
  - Shifting from Volume to Value-Based payments
  - Program alignment and streamlining
  - Update on CMS payment policies
- **Health System Transformation: MACRA 2015**
  - The Quality Payment Program
  - Options for participation in 2017
  - Opportunities for technical support

CMS OFFICES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Million Hearts®

Goal: Prevent 1 million heart attacks and strokes by 2017

- National initiative co-led by CDC and CMS
- In partnership with federal, state, and private organizations innovating and implementing
- To address the causes of 1.5M events and 800K deaths a year → $312.6 B in annual health care costs and lost productivity and major disparities in outcomes

Key Components of Million Hearts®

Excelling in the ABCS
Optimizing care

Prioritizing the ABCS

Health tools and technology

Innovations in care delivery

Keeping Us Healthy
Changing the context

Health Disparities

Million Hearts and the Health Center Program

HRSA-funded health centers address risk factors for cardiovascular disease. We do this as part of the HHS Million Hearts initiative to prevent 1 million heart attacks and strokes by the end of 2017.

Clinical Quality Measures

80,000 ***More Patients**** received aspirin therapy when appropriate in 2015 than in 2013

260,000 ***More Patients**** with hypertension achieved blood pressure control in 2015 than in 2013

800,000 ***More Patients**** were screened for tobacco use and provided needed cessation intervention in 2015 than in 2014

Million Hearts Recognition

226 ***Health Centers**** received a Million Hearts badge. Each achieved > 70% on aspirin use, blood pressure control, and tobacco cessation measures

*According to 2015 UDS Data

Million Hearts Hypertension Control Champions

in 2014 + *in 2015* = **18** ***Health Centers*** **use innovative approaches to achieve hypertension control rates at or above 70%**

https://millionhearts.hhs.gov/partners-progress/champions/index.html

Resource Distribution

19,000 health centers and stakeholders received Heart Month messages and Million Hearts' Tobacco Cessation Protocols through the HRSA newsletters

Million Hearts® 2022
Opportunities in U.S. Adults

Blood Pressure	Cholesterol	Sodium	Physical Activity	Tobacco Use
34 M	**35M/42M**	**215M**	**124 M**	**36.5 M**
Uncontrolled	**Unmanaged**	**Overconsumed**	**Underexerting**	**Smoke**

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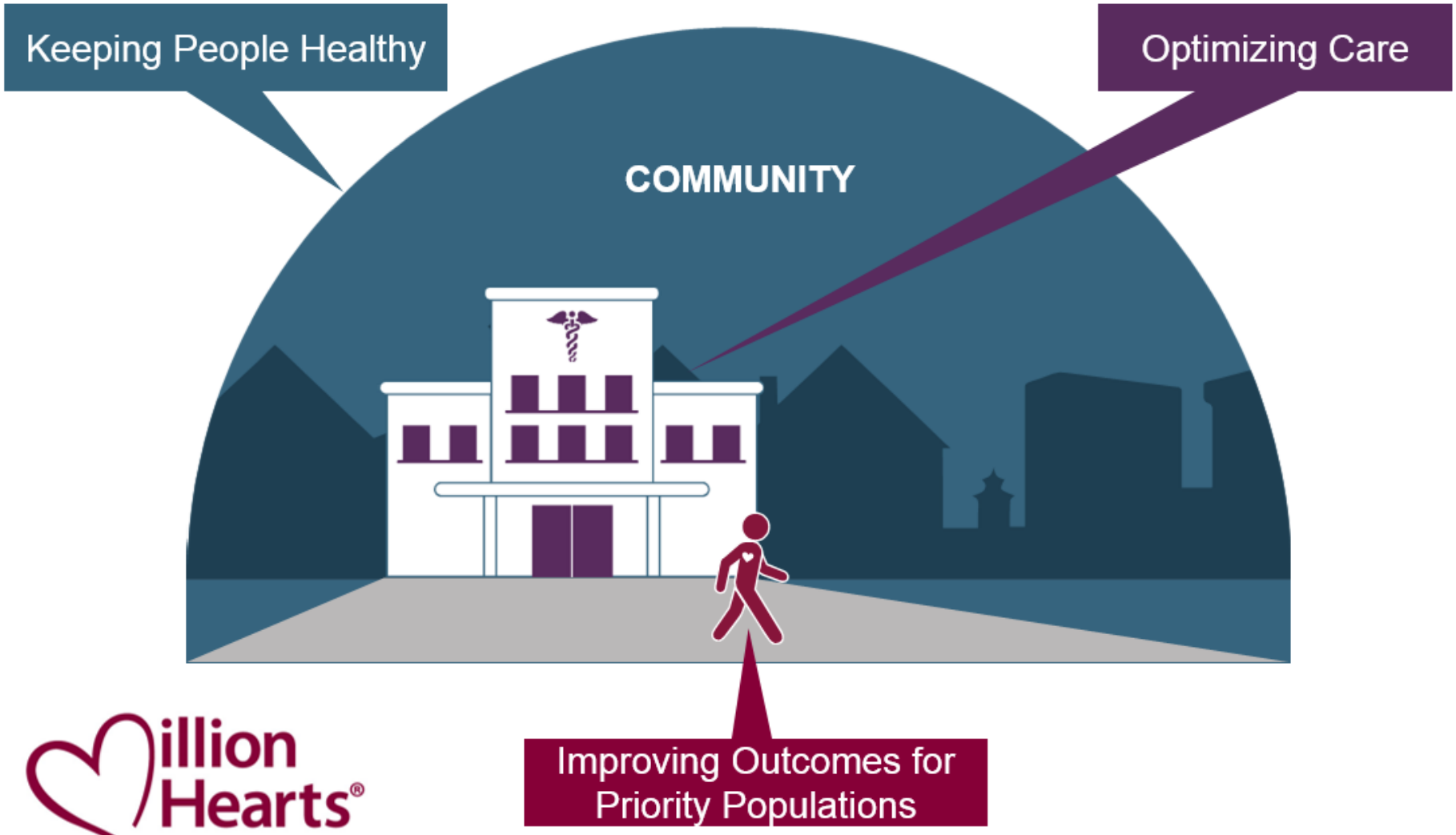
Million Hearts® 2022 Aim:
Prevent a Million Heart Attacks and Strokes in Five Years



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Million Hearts® 2022
Priorities

Keeping People Healthy
Reduce Sodium Intake
Decrease Tobacco Use
Increase Physical Activity

Optimizing Care
Improve ABCS*
Increase Use of Cardiac Rehab
Engage Patients in Heart-healthy Behaviors

Improving Outcomes for Priority Populations
Blacks/African-Americans
35-64 year olds
People who have had a heart attack or stroke
People with mental illness or substance use disorders

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*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

Keeping People Healthy

Goals	Effective Public Health Strategies
Reduce Sodium Intake 20% Target	• Enhance consumers' options for lower sodium foods • Institute healthy food procurement and nutrition policies
Decrease Tobacco Use 20% Target	• Enact smoke-free space policies that include e-cigarettes • Use pricing approaches • Conduct mass media campaigns
Increase Physical Activity 20% Target (Reduction of inactivity)	• Create or enhance access to places for physical activity • Design communities and streets that support physical activity • Develop and promote peer support programs

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Optimizing Care

Goals	Effective Healthcare Strategies
Improve ABCS* 80% Targets	*High Performers Excel in the Use of…….* • **Technology** – decision support, patient portals, e- and default referrals, registries, and algorithms to find gaps in care • **Teams** – including pharmacists, nurses, community health workers, cardiac rehab professionals • **Processes** – treatment protocols; daily huddles; ABCS scorecards; proactive outreach; finding patients with undiagnosed high BP, high cholesterol, or tobacco use • **Patient and Family Supports** – training in home blood pressure monitoring; problem-solving in medication adherence; counseling on nutrition, physical activity, tobacco use, risks of particulate matter; referral to community-based physical activity programs and cardiac rehab
Increase Use of Cardiac Rehab 70% Target	
Engage Patients in Heart-healthy Behaviors Targets TBD	

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*Aspirin, Blood pressure control, Cholesterol management, Smoking cessation

Improving Outcomes for Priority Populations

Priority Populations	Major Strategies
Blacks/African-Americans	Improving hypertension control
35-64 year olds—because event rates are rising	• Improving hypertension control and statin use • Increasing physical activity
People who have had a heart attack or stroke	• Increasing cardiac rehab referral & participation • Avoiding exposure to particulate matter
People with mental illness or substance use disorders	Reducing tobacco use

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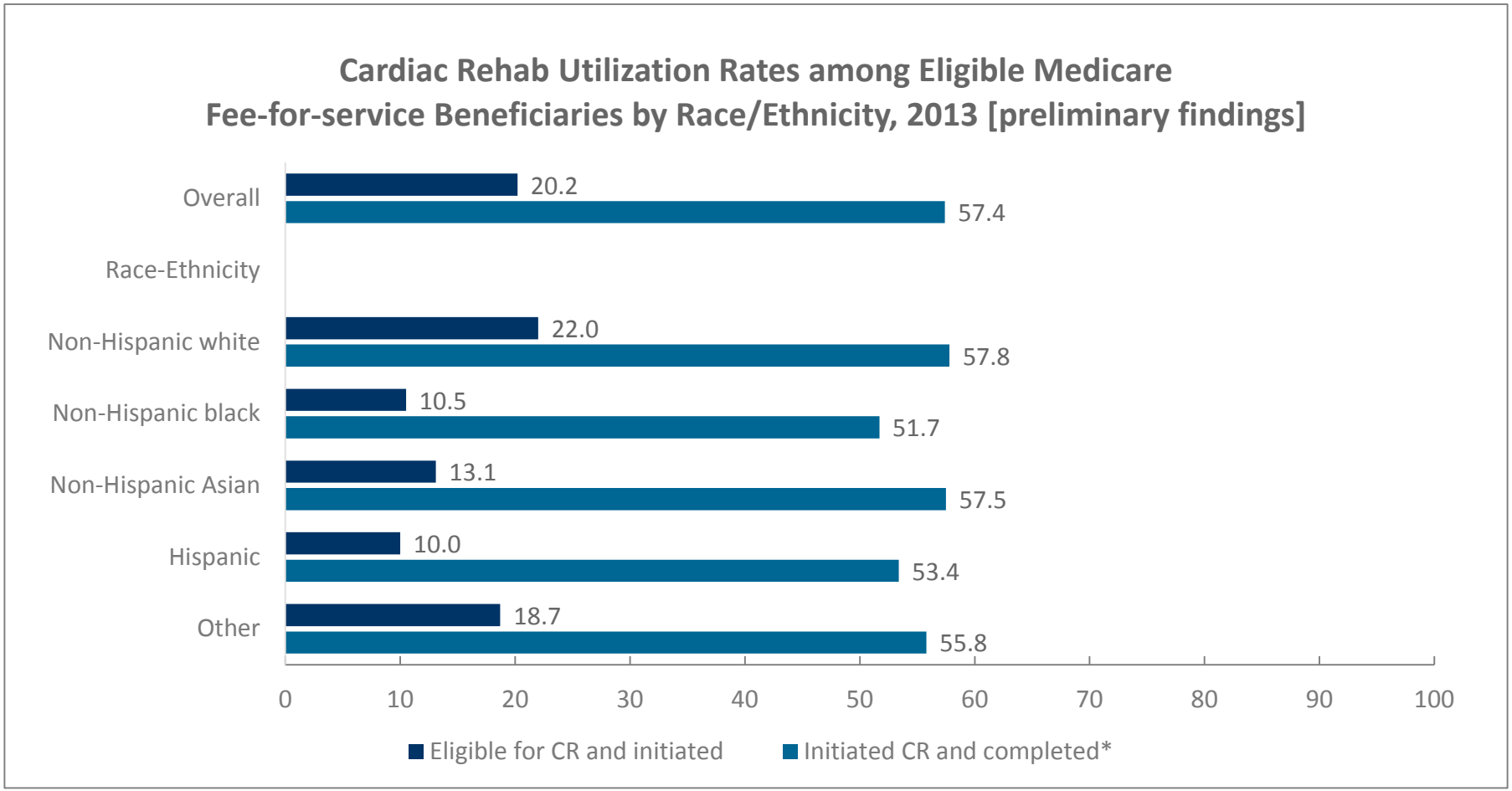
Cardiac Rehab



*Completed 25 or more CR sessions

Source: Centers for Medicare and Medicaid Services' Chronic Conditions Data Warehouse

Cardiac Rehabilitation:
What is it?

Comprehensive, team-delivered programs designed to:

- Limit the physiologic and psychological effects of cardiac illness
- Reduce the risk for sudden death or re-infarction
- Control cardiac symptoms
- Stabilize or reverse the atherosclerotic process
- Enhance the psychosocial and vocational status of selected patients

Typically administered via 36 sessions over ~12 weeks

DHHS, PHS, AHCPR, NHLBI. Clinical Guideline No. 17. 1995

Cardiac Rehabilitation

Saving Lives ♥ Restoring Health ♥ Preventing Disease

Benefits of Cardiac Rehabilitation

Benefits to People

Those who attend 36 sessions have a **47%** lower risk of death and **31%** lower risk of heart attack than those who attend only one session.

Benefits to Health Systems

Costs per year of life saved range from **$4,950 to $9,200** per person.

Cardiac rehab participation also reduces hospital readmissions.

Most significant barrier in literature: *Referrals*

Referral barriers → CR program is not integrated into CV services → "Opt-in" instead of "opt-out" hospital discharge orders

↓

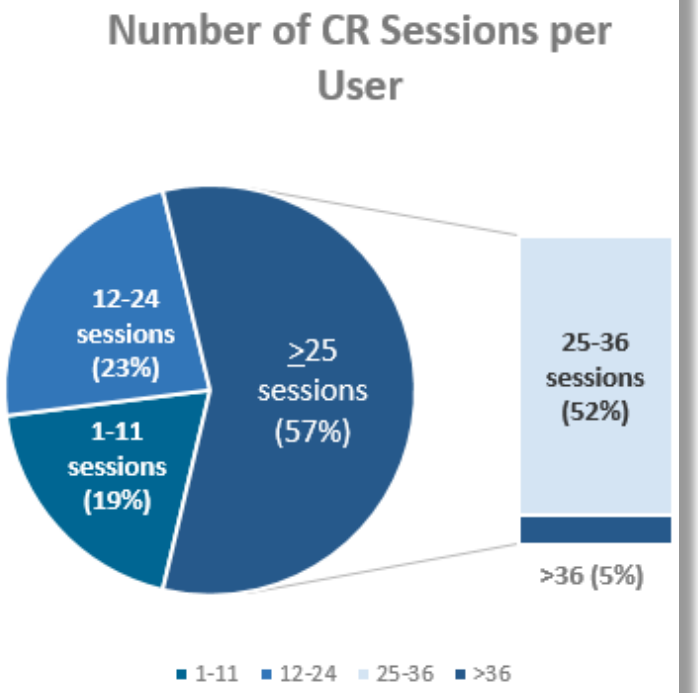
Lack of awareness of the benefits by referring MDs

No clear, consistent signal to patients and families

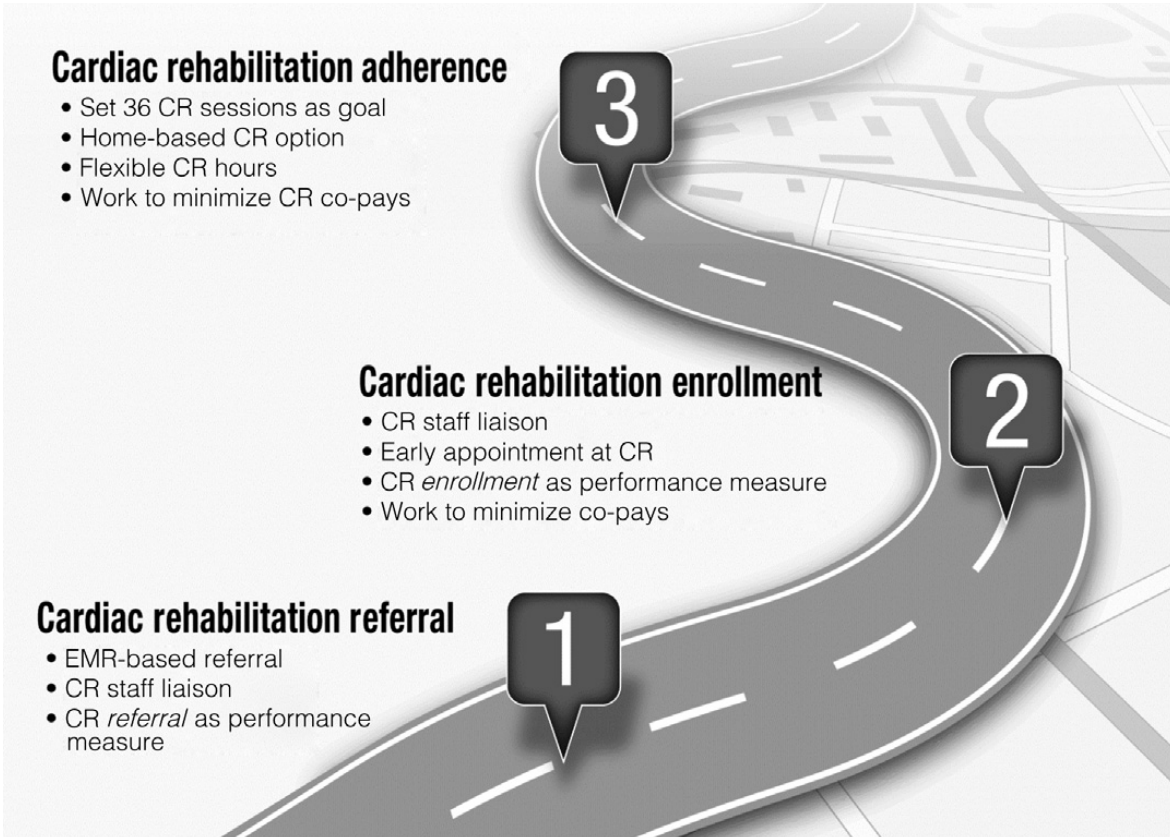
Cardiac Rehab Utilization among Medicare Fee-for-service Beneficiaries

Approximately 450,000 FFS beneficiaries were eligible for CR in 2013

- 20% used CR at least once in 12 months
- 57% of CR users completed 25 or more sessions



Roadmap to 70% Cardiac Rehab Participation



Ades PA, et. al., Increasing Cardiac Rehabilitation Participation From 20% to 70%: A Road Map From the Million Hearts Cardiac Rehabilitation Collaborative, (2016) DOI.

https://millionhearts.hhs.gov/data-reports/reports.html

Participation and Completion

Reaching the 36 Session Threshold Is Challenging

Longer wait times following discharge reduce cardiac rehab enrollment.

For every day a person waits to start cardiac rehab, they are 1% less likely to enroll in cardiac rehab.

People who live outside of metropolitan areas are 30% less likely to participate in cardiac rehab programs.

Cardiac Rehab Participation Rates by Race (601,000 Medicare Patients)

19.6% of eligible white patients participate

7.8% of eligible black patients participate

We Know from Research How To Eliminate Barriers

The greatest predictor of participation is the strength of the physician's recommendation.

Reduce the interval between hospital discharge and cardiac rehab program orientation by formalizing enrollment practices.

Ensure access to services, through transportation options and extended hours.

Where possible, reduce or eliminate financial burden on cardiac rehab participants.

Support participation in cardiac rehab through community health workers, home health aides, and visiting nurses.

A Small Set of High Impact Measures, Widely Embedded

Focuses Action, Reduces Burden, Strengthens Performance Assessment

Million Hearts® Quality Measure Alignment in National Quality Reporting Systems

	Primary Measures				Secondary Measures	
Quality Reporting Initiative	**Aspirin when Appropriate**	**Blood Pressure Control**	**Cholesterol Management**	**Smoking Assessment and Treatment**	**Cardiac Rehab Referral**	**BMI**
CMS Quality Payment Program	✓	✓	✓	✓	✓	✓
AHRQ EvidenceNow	✓	✓	✓	✓	✓	No
ABFM Prime Registry	✓	✓	✓	✓	✓	✓
AHA Guideline Advantage	✓	✓	No	✓	✓	✓
ACP Genesis Registry	✓	✓	No	✓	✓	✓
ACC PINNACLE Registry	No	✓	No	✓	✓	No
CMS Shared Savings ACO	✓	✓	No	✓	✓	✓
TCPI	✓	✓	No	✓	✓	✓
CMS Home Health CV Data Registry	✓	✓	No	✓	✓	No
HRSA Uniform Data System	✓	✓	Pending‡	✓	✓	✓
Comprehensive Primary Care	No	✓	No	✓	✓	No
IHS RPMS	No	✓	Pending‡	✓	✓	✓
Medicaid Adult Core Set	No	✓	No	0027†	✓	No

✓Indicates measure alignment as of February 2017

† Measure is not identical, but similar and meets stakeholders needs

‡ Measure will be added for reporting in 2019 after e-specifications are released in May 2017

NOTE: ABCS measures are in the Cardiology, Internal Medicine, and General Practice/Family Medicine Specialty Measure Set

Million Hearts® 2022 Clinical Quality Measures

Measure	Measure Number	Measure Description
Aspirin When Appropriate	NQF 0068	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic** Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic
Blood Pressure Control	NQF 0018	**Hypertension: Controlling High Blood Pressure** % of patients aged 18 - 85 years with a diagnosis of HTN and an office BP of <140/90 during the measurement year
Cholesterol Management	PQRS 438	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease** % who were prescribed or on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR • Adults aged ≥21 years with a fasting or direct LDL-C level ≥ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL
Smoking Cessation	NQF 0028	**Preventive Care and Screening: Tobacco Use** % of patients ≥18 years who were screened about tobacco use one or more times within 24 months and who received cessation counseling intervention if a tobacco user
Cardiac Rehab Referral	NQF 0643 NQF 0642	**Referral to CR from Inpatient or Outpatient Setting** % of patients with an eligible diagnosis who are referred from a hospital (or office) to an early outpatient CR program
BMI	NQF 0421	**Screening and Follow-Up** % of patients ≥ 18 years with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter.

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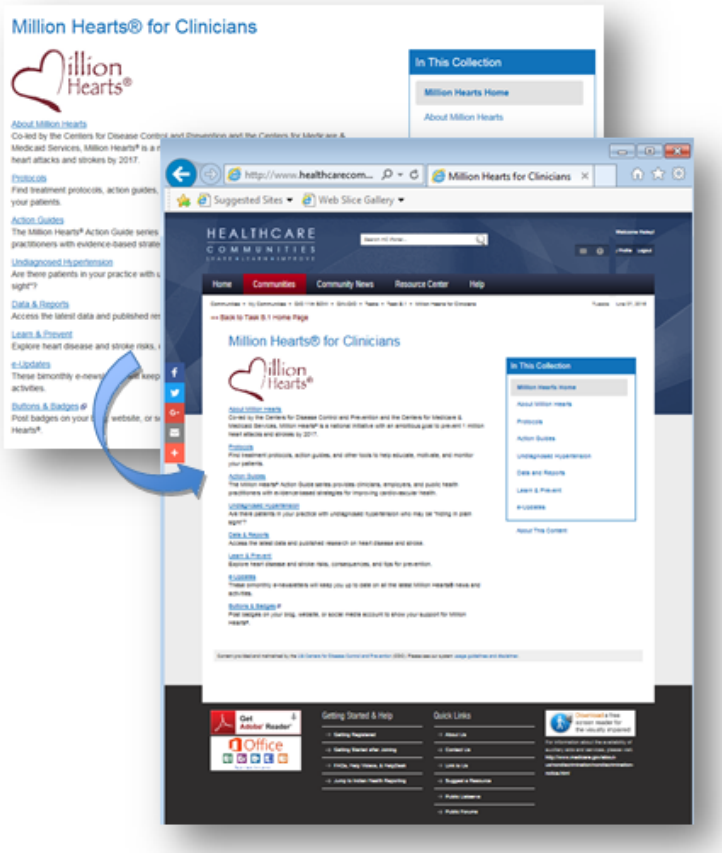
The Million Hearts Microsite

Make Million Hearts Resources Your Own

- Includes Million Hearts® evidence-based protocols, action guides, and other QI tools
- Syndicates Million Hearts® content through your website for your clinical audience
- A small amount of code - customizable by color and responsive to layouts and screen sizes - is used to embed microsite.
- Content is cleared and continuously maintained by CDC



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Now LIVE at https://tools.cdc.gov/medialibrary/index.aspx#/microsite/id/279017

Better Care, Smarter Spending, Healthier People

Focus Areas	Description
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.

2017 Medicare Physician Fee Schedule Final Rule Released November 2, 2016

- Finalizes a number of changes to identify and value primary care, care management, and cognitive services:
  - Separate payments for certain CPT codes describing non-face-to-face prolonged evaluation and management services
  - Revalues existing CPT codes describing face-to-face prolonged services.
  - Separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairment
  - Separate payments using new codes to pay primary care practices that use inter-professional care management resources to treat patients with behavioral health conditions.
    - Emphasis on behavioral health integration models of care
  - ake separate payments for codes describing chronic care management for atients with greater complexity.

Medicare Physician Fee Schedule Final Rule Released November 2, 2016

- **Expands the Diabetes Prevention Program** model starting Jan 2018
- **Finalizes the list of services eligible to be furnished via telehealth, including:**
  - End-stage renal disease (ESRD)-related services for dialysis;
  - Advance care planning services;
  - Critical care consultations furnished via telehealth using new Medicare G-codes.
- **Finalizes payment policies related to** the use of a new place of service code specifically designed to report services furnished via **telehealth**
- **Finalizes values for the new CPT moderate sedation codes**
  - Uniform methodology for valuation of the procedural codes that currently include moderate sedation
  - Adds CPT codes including an endoscopy-specific moderate sedation code
- **Finalizes revisions to payment for care management**
  - Payment for new codes for complex chronic care management
    t for extra care management following the initiating visit for patients with
    chronic conditions

Reminder about HIV and Hep C screening

- **HIV screening**
  - Medicare Part B covers HIV (Human Immunodeficiency Virus) screenings
    - Medicare covers this test once every 12 months for people who meet criteria
      - 15-65 years old and ask for the screening
      - Younger than 15 or older than 65, are at increased risk, and ask for the screening
    - Medicare also covers this screening up to 3 times during a pregnancy
- **Hepatitis C screening**
  - Medicare covers one Hepatitis C screening, and also covers yearly repeat screening for certain people at high risk:
    - Those at high risk because they have a current or past history of illicit injection drug use
    - Those who had a blood transfusion before 1992
    - Those born between 1945-1965
  - **Reminder:** Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care clinician as a screening test

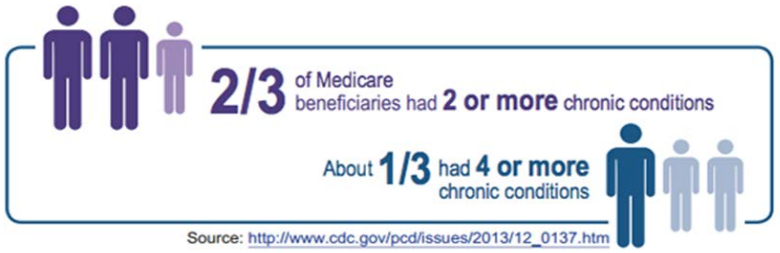
Chronic Disease Burden in the United States

Chronic Care Overview

- Half of all adult Americans have a chronic condition – 117 million people
- One in four Americans have 2+ chronic conditions
- 7 of the top 10 causes of death in 2014 were from chronic diseases
- People with chronic conditions account for 86% of national healthcare spending
- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care

CMS and Chronic Care

- Medicare benefit payments totaled $597 billion in 2014
- Two-thirds of Medicare beneficiaries have 2+ chronic conditions
- 99% of Medicare spending is on patients with chronic conditions
- Annual per capita Medicare spending increases with beneficiaries' number of chronic conditions



Sources: CMS, CDC, Kaiser Family Foundation, AHRQ

What Is Chronic Care Management (CCM)?

Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist and/or Certified Nurse Midwife) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline

- Timed services – threshold amount of clinical staff time performing qualifying activities is require per month
- CCM is a critical component of care that contributes to better health and care for individuals
- CCM offers more centralized management of patient needs and extensive care coordination among practitioners and providers

Management (CCM)?

Ongoing CMS effort to pay more accurately for CCM in “traditional” Medicare by identifying gaps in Medicare Part B coding and payment (especially the Medicare Physician Fee Schedule or PFS)

- Initially adopted **CPT code 99490** beginning January 1, 2015 to separately identify and value clinical staff time and other resources used in providing CCM
- Beginning January 1, 2017, CMS adopted **3 additional billing codes (G0506, CPT 99487, CPT 99489)**
- Detailed guidance on CCM and related care management services for physicians available on the PFS web page at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

What's new for CY 2017

Significant changes starting in 2017 based on feedback from stakeholders.

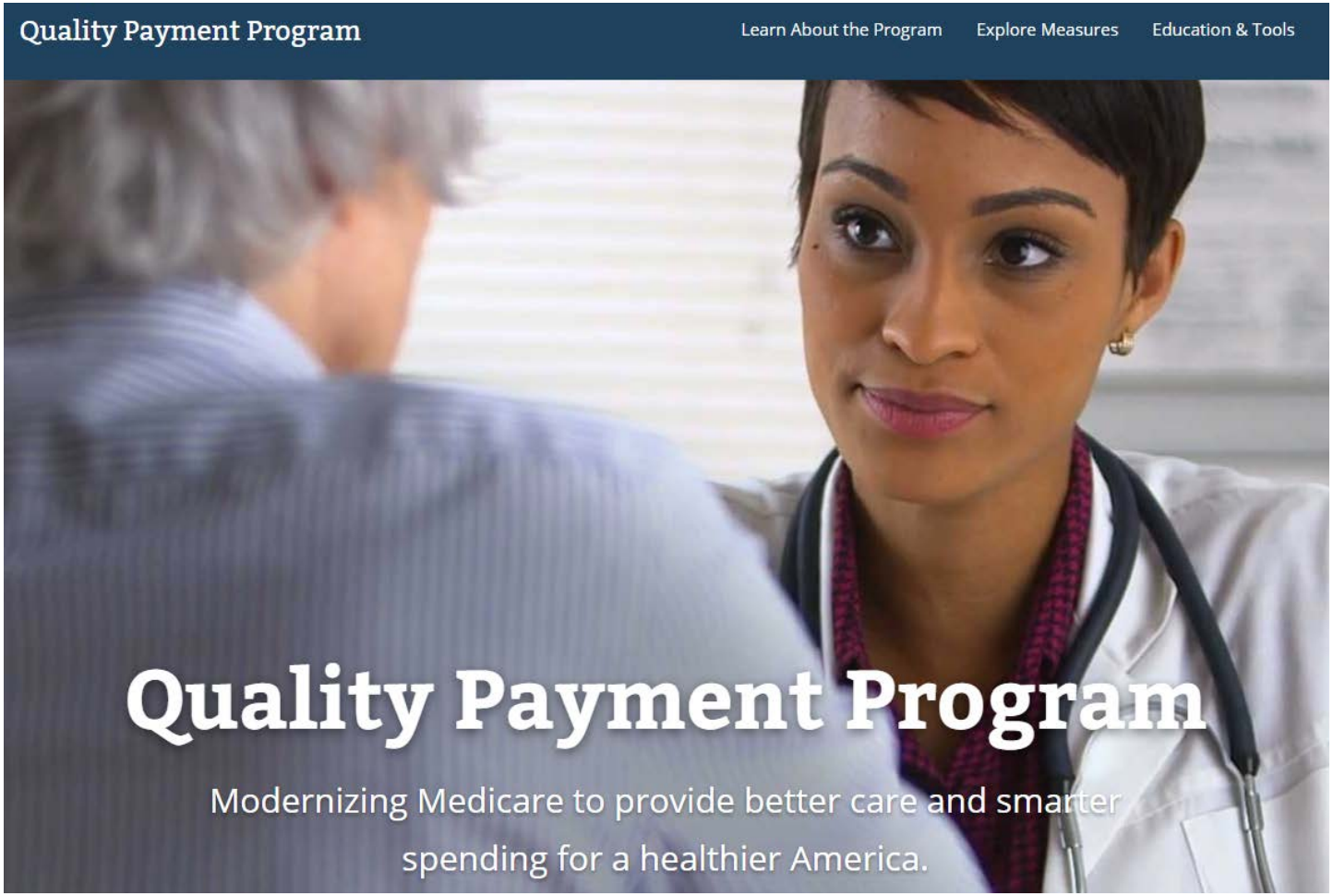
- Additional separate payment amount through three new billing codes
  - **G0506** (Add-On Code to CCM Initiating Visit, $64)
  - **CPT 99487** (Complex CCM, $94)
  - **CPT 99489** (Complex CCM Add-On, $47)
- **CPT 99490** still effective for Non-Complex CCM ($43)

Visit the *Connected Care* Resource Hub at: **http://go.cms.gov/CCM**

For questions about the *Connected Care* campaign and its resources, contact, **CCM@cms.hhs.gov**

For all CCM codes – Simplified and reduced billing and documentation rules, especially around patient consent and use of electronic technology.

Website: https://qpp.cms.gov



Origins of the Quality Payment Program: MACRA

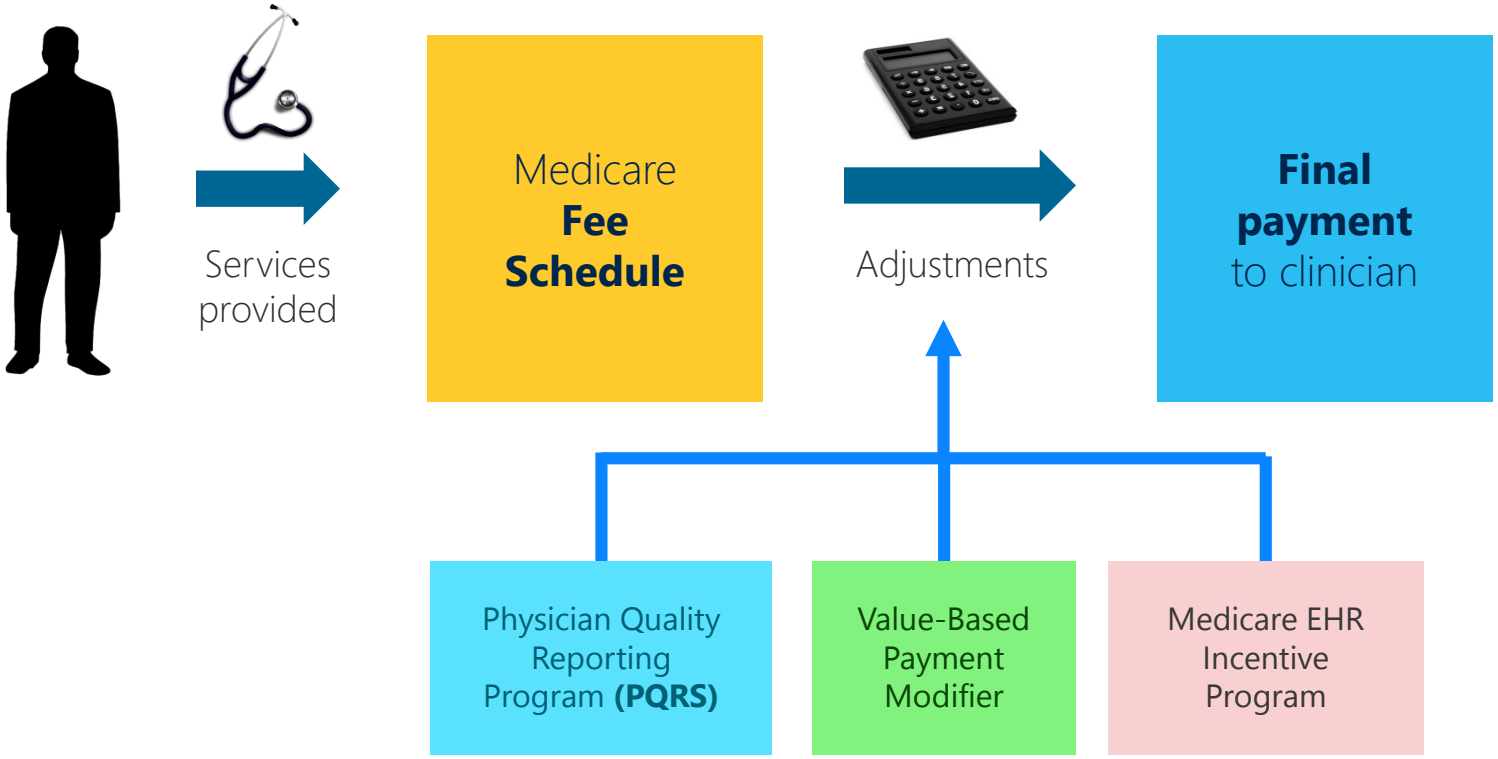
- Bipartisan Legislation: the "Medicare Access and CHIP Reauthorization Act," 2015

- 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

Services provided

Medicare **Fee Schedule**

Adjustments

Final payment to clinician

MIPS

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.

OR

Advanced APMs

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 Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

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.

OR

Advanced APMs

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.

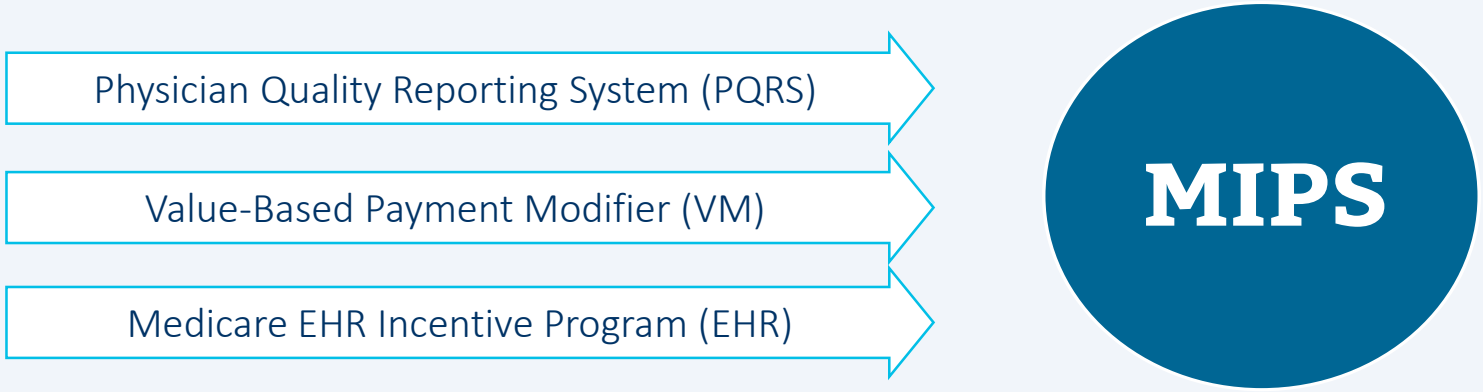
Discussion Structure

- Part 1: What do I need to know about MIPS?
- Part 2: What do I need to know about APMs?
- Part 3: How do I prepare for and participate in The Quality Payment Program?

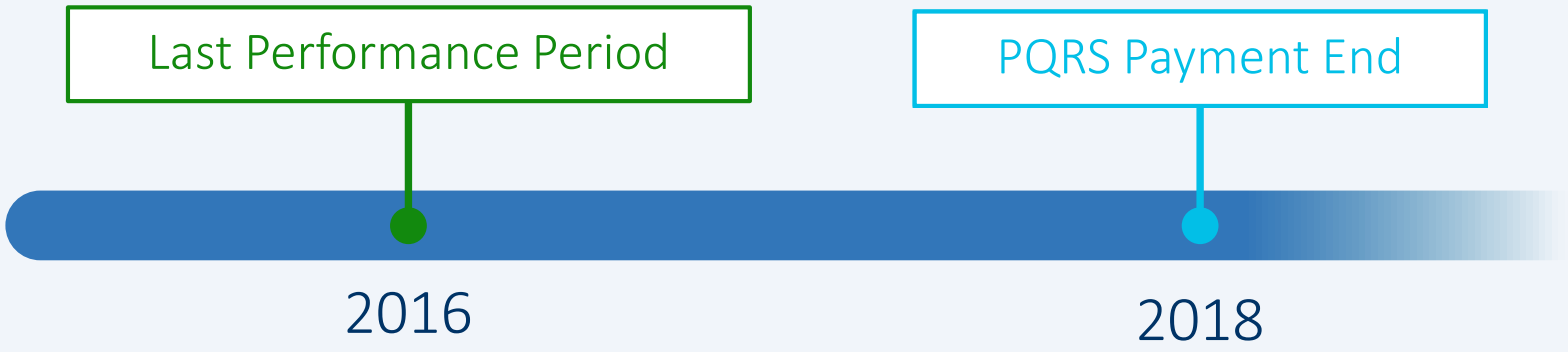
Part I:
MIPS Basics
What Do I Need to Know?

What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program



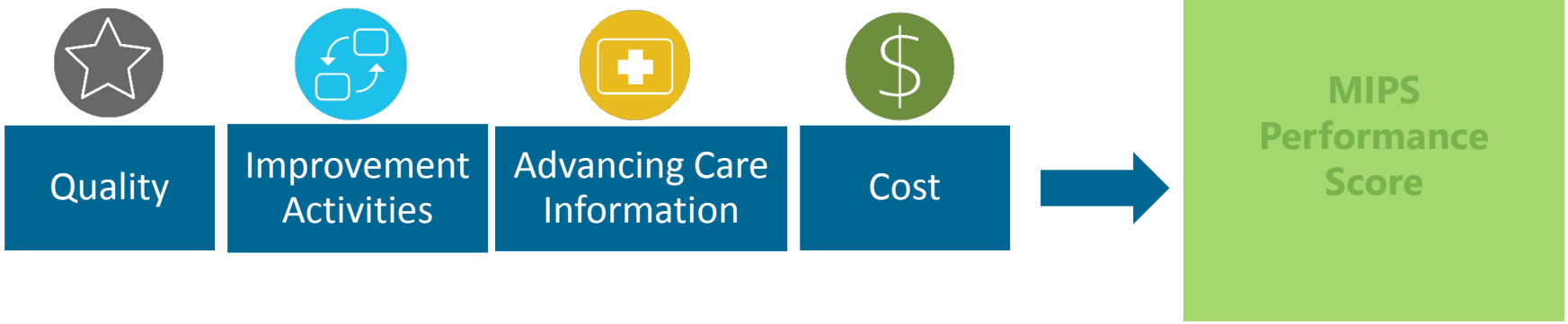
Legacy Program Phase Out



What Is MIPS?

https://qpp.cms.gov

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

What are the Performance Category Weights?

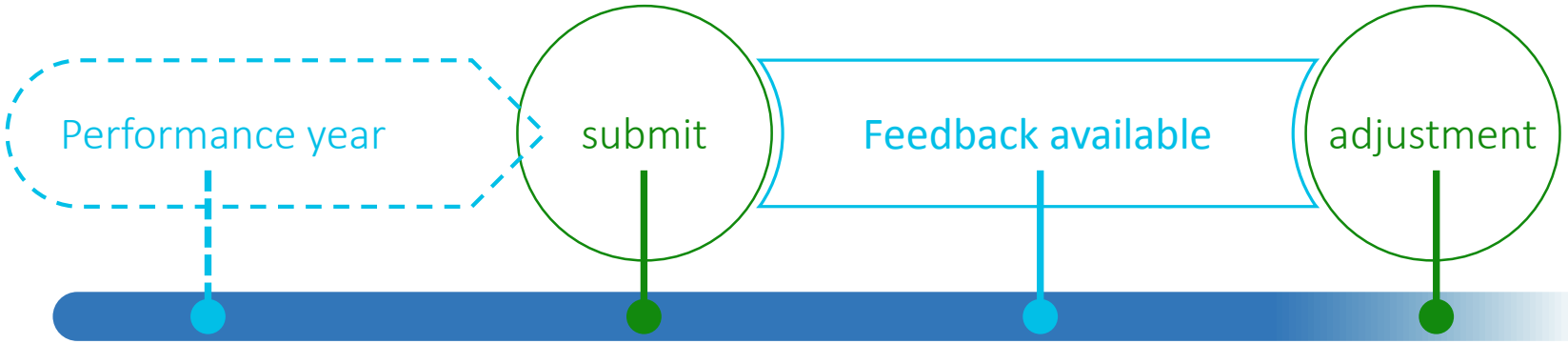
Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%

Note: These are defaults weights; the weights can be adjusted in certain circumstances

When Does the Merit-based Incentive Payment System Officially Begin?



Performance Year

- Performance period opens January 1, 2017.
- Closes December 31, 2017.
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.

MIPS Eligibility
What Do I Need to Know?

Eligible Clinicians:

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

These clinicians include:

Physicians	Physician Assistants	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetists

Exempt Example

Dr. "B." is:

- An eligible clinician
- Billed $100,000 in Medicare Part B charges
- Saw 80 patients

Dr. B. would be *EXEMPT* from MIPS due to seeing less than 100 patients.

Remember: To be eligible

Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies **are not** subject to the MIPS payment adjustment.

    However…

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) **are** required to participate in MIPS and are subject to a payment adjustment.

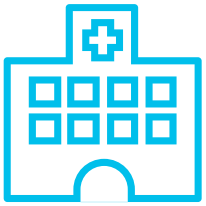
Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is $\leq$ 100 patient facing encounters in a designated period
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- There are more flexible reporting requirements for non-patient facing clinicians

MIPS Participation
What Do I Need to Know?

Pick Your Pace for Participation for the Transition Year

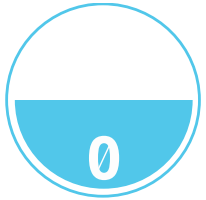
Participate in an Advanced Alternative Payment Model



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

MIPS

Test



Submit Something

- Submit **some** data after January 1, 2017
- Neutral payment adjustment

Partial Year

Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Neutral or positive payment adjustment

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS: Choosing to Test for 2017

Submit Something

- Submit **minimum** amount of 2017 data to Medicare
- **Avoid** a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

1
Quality
Measure

OR

1
Improvement
Activity

OR

4 or 5*
Required
Advancing
Care
Information
Measures

*Depending on CEHRT edition

MIPS: Partial Participation for 2017

Submit a Partial Year

- Submit **90 days** of 2017 data to Medicare
- May earn a positive payment adjustment

"So what?" - If you're not ready on January 1, you can start anytime between January 1 and October 2

Need to send performance data by **March 31, 2018**

MIPS: Full Participation for 2017

Submit a Full Year

- Submit a **full year** of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to **earn largest payment adjustment** is to submit data on all MIPS performance categories

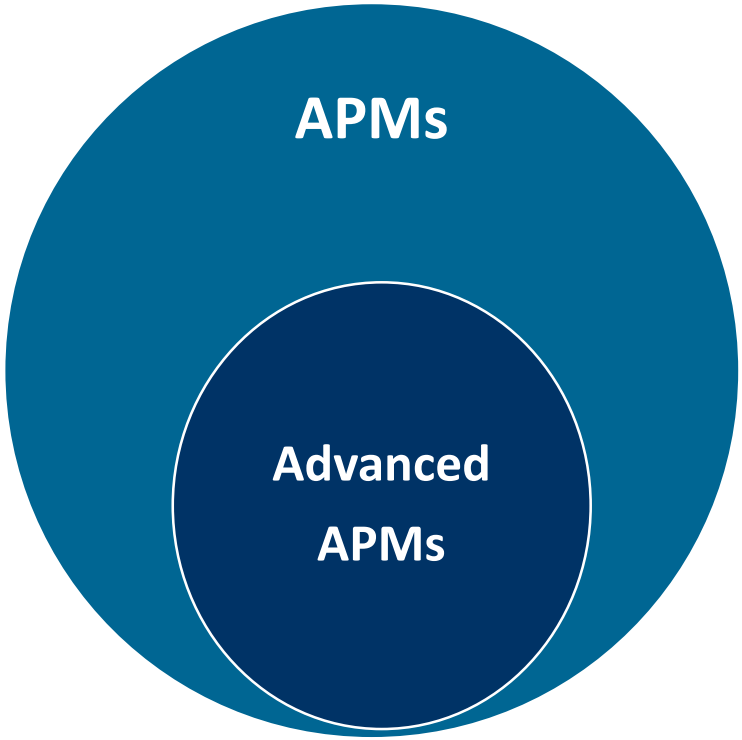
Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

Part II:
APM Basics
What Do I Need to Know?

Alternative Payment Models (APMs)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can apply to a specific condition, care episode or population.
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;
2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

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 QPP.CMS.GOV and will be updated with new announcements as needed.

Advanced Alternative Payment Models

Clinicians who participate significantly in Advanced APMs can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

How do Eligible Clinicians become Qualifying APM Participants?

- ✓ The Threshold Score is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Part III: Checklist for Preparing and Participating in MIPS

Preparing and Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit **qpp.cms.gov** for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 2018.

❑ Determine Your Eligibility

How Do I Do This?

1. Calculate your annual patient count and billing amount for the 2017 transition year.
   - Review your claims for service provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.
   - Did you bill more than $30,000 **AND** provide care for more than 100 Medicare patients a year?
     - Yes: You're eligible.
     - No: You're exempt.
2. CMS will provide additional guidance on eligibility in Winter/Early Spring 2017.

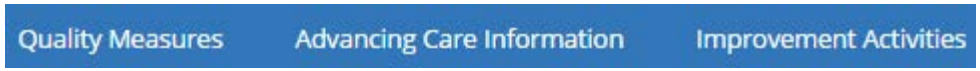
❑ Choose Your Measures/Activities

How Do I Do This?

1. Go to **qpp.cms.gov**.

2. Click on the **Explore Measures** tab at the top of the page.

3. Select the performance category of interest.



4. Review the individual Quality and Advancing Care Information measures as well as Improvement Activities.

https://qpp.cms.gov

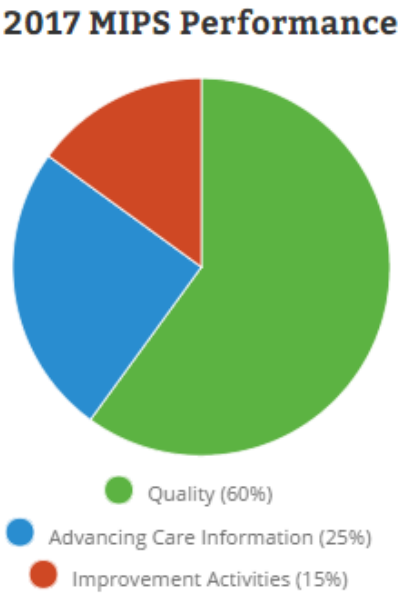
Quality Measures

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, chose 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 can't use it to submit or attest to measures or activities.



Select Measures

Search All by keyword

All | Search for... | SEARCH

Filter by:

High Priority Measure | Data Submission Method | Specialty Measure Set

Technical Support Available to Clinicians

Integrated Technical Assistance Program

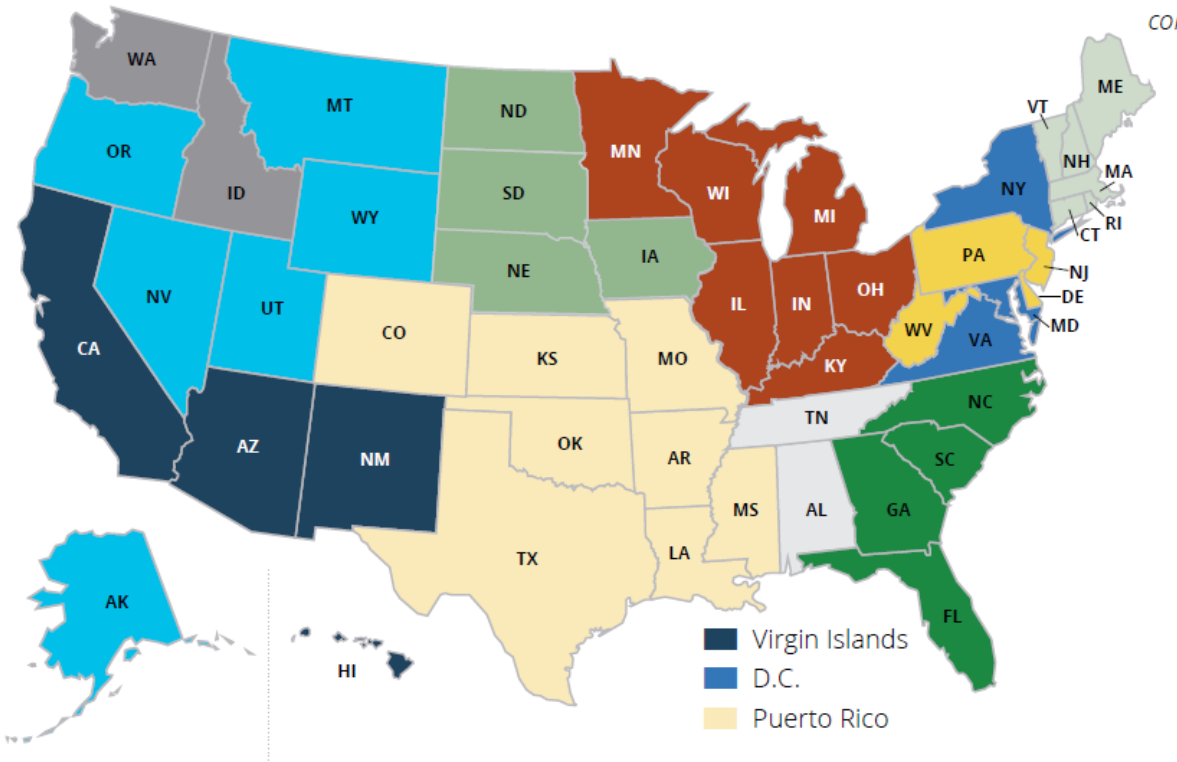
- **Full-service, expert help**
  - Quality Payment Program Service Center
  - Quality Innovation Network/Quality Improvement Organizations
  - Quality Payment Program — Small, Underserved, and Rural Support
  - Transforming Clinical Practice Initiative
  - APM Learning Networks

- **Self-service**
  - QPP Online Portal

All support is FREE to clinicians

https://qpp.cms.gov/education

For general information or for help getting connected, contact QPPSURS@IMPAQINT.COM



Coverage by Organization

- Healthcentric Advisors
- IPRO
- Quality Insights (WVMI)
- Alliant GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

Additional Resources

Quality Payment Program:
qpp.cms.gov
1-866-288-8292
TTY: 1-877-715-6222
QPP@cms.hhs.gov

APM Learning Model Support List:
http://innovation.cms.gov

Transforming Clinical Practice Initiative (TCPI):
PTN Map: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices
To enroll in TCPI, contact:
TCPI.ISC@Truvenhealth.com

Quality Improvement Organizations:
QIN-QIO Map:
http://qioprogram.org/

Quality Payment Program: How to get help

Need Help

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

Questions

Send us your questions about the Quality Payment Program to

QPP@cms.hhs.gov

Ashby Wolfe, MD, MPP, MPH

Chief Medical Officer, Region IX

Centers for Medicare and Medicaid Services

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