An IHS Overview of
The Quality Payment Program - MACRA

Susy Postal DNP, RN-BC
Chief Health Informatics Officer

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This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Important Note: This presentation was developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

Slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.
Objectives

1. Identify the background and purpose of the Quality Payment Program (QPP): Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

2. Review the final rule with comments, addressing framework paths: Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).

3. Discuss payment adjustments and bonuses related to MIPS and APMs.

4. Discuss the impact to clinicians.

5. Identify steps to prepare for the Quality Payment Program within the IHS.
The Department of Health and Human Services Goals

Quality Payment Program moves us closer to meeting these goals

The new Merit-based Incentive Payment System helps to link fee-for-service payments to quality and value.

The law also provides incentives for participation in Alternative Payment Models in general and bonus payments to those in the most highly advanced APMs.

New HHS Goals:

- **2016**
  - 30%
  - 85%
- **2018**
  - 50%
  - 90%

All Medicare fee-for-service (FFS) payments (Categories 1-4)
Medicare FFS payments linked to quality and value (Categories 2-4)
Medicare payments linked to quality and value via APMs (Categories 3-4)
Medicare Payments to those in the most highly advanced APMs under MACRA
Quality Payment Program (QPP)

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new **Merit-based Incentive Payment System (MIPS)**
- **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**
- First step to a fresh start
- CMS is listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric
Timeline

April 27, 2016: Notice of Proposed Rule Making  
May 2016: Quality Measure Development Plan finalized  
June 27, 2016: Public Comments  
October 14, 2016: Final Rule  
2017: Performance Period (MIPS & APMs)  
2019: Payment Year for Quality Payment Program

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<tbody>
<tr>
<td>Performance Period</td>
<td>Payment Year</td>
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Submit a Formal Comment

CMS encourages the public to submit comments on the MACRA final rule. Comments are due on December 19, 2016, and can be submitted in several ways, including:

- Electronically via https://www.regulations.gov
- By regular mail
- By express or overnight mail
- By hand or courier
Quality Payment Program: Pick Your Pace

- Ready - Begin January 1, 2017
- Not Quite Ready
- Send in Performance Data by March 31, 2018
Which clinicians does The Quality Payment Program affect?
(Will it affect me?)

Short answer: Quality Payment Program affects clinicians who participate in Medicare Part B.
Quality Payment Program: Two Paths

Health care providers to take part in CMS’ quality programs in one of two ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (APMs)
Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (VM)**
- **Medicare Electronic Health Records (EHR) Incentive Program**

The Quality Payment Program/MACRA streamlines those programs into **MIPS**
MIPS Performance Categories

How will physicians and practitioners be scored under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Clinical practice Improvement Activities
- Advancing Care Information
- *Cost

*Cost = 0 % weighting the first year
Year 1 Performance Category Weights for MIPS

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

**Cost**: Counted starting in 2018
Quality

Replaces the Physician Quality Reporting System (PQRS).

☑️ For full participation, most participants:
  - Report 6 quality measures (including an outcome measure or high priority measure)
  - Minimum of 90 days.

☐ Groups using the web interface:
  - Report 15 quality measures
  - Full year

☐ Groups in APMs qualifying for special scoring 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 MIPS quality.

☐ Select Quality Measure Resource https://qpp.cms.gov/measures/quality
Advancing Care Information (ACI)

Fulfill the required measures for a minimum of 90 days:

1. Security Risk Analysis
2. e-Prescribing
3. Provide Patient Access
4. Send Summary of Care
5. Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

Base score, performance score and bonus score - Ability to earn up to 155 percentage points which will be capped at 100 percent.

Submitting 4 or 5 base score measures – depends on use of 2014 or 2015 Edition
### TABLE 9: Advancing Care Information Performance Category Scoring Methodology Advancing Care Information Objectives and Measures

<table>
<thead>
<tr>
<th>Advancing Care Information Objective</th>
<th>Advancing Care Information Measure*</th>
<th>Required/Not Required for Base Score (50%)</th>
<th>Performance Score (up to 90%)</th>
<th>Reporting Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>Required</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
<td>Required</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
<td>Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient-Specific Education</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td>Coordination of Care Through Patient Engagement</td>
<td>View, Download, or Transmit (VDIT)</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secure Messaging</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient-Generated Health Data</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
<td>Required</td>
<td>Up to 10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Request/Accept Summary of Care</td>
<td>Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td></td>
<td>Clinical Information Reconciliation</td>
<td>Not Required</td>
<td>Up to 10%</td>
<td>Numerator/Denominator</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Immunization Registry Reporting</td>
<td>Not Required</td>
<td>0 or 10%</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting</td>
<td>Not Required</td>
<td>Bonus</td>
<td>Yes/No Statement</td>
</tr>
</tbody>
</table>

Federal Register/ Final Rule with Comment Period P. 768
Improvement Activities (IA)

- For full participation, most participants:
  - Attest 4 improvement activities completed
  - Minimum of 90 days.

- Groups with fewer than 15 participants, non-patient facing clinicians, or if you are in a rural or health professional shortage area:
  - Attest up to 2 activities completed
  - Minimum of 90 days.

- Participants in certified patient-centered medical homes (PCMH), comparable specialty practices, or an APM designated as a Medical Home Model:
  - You will automatically earn full credit.
Cost

- No data submission required
- Calculated from adjudicated claims
- For the transition year, the cost performance category will **not** impact payment in 2019
- Starting in 2018, the cost category will be used to determine your payment adjustment.
Who Will Participate in MIPS?

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

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS.

**Years 1 and 2**
- Doctors of Medicine, Doctors of Osteopathy, Chiropractors, Dentists, Optometrists, Podiatrists, Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, And Clinical Nurse Specialists

**Years 3+**
- Secretary may broaden Eligible Clinicians group to include others such as
- Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **Certain participants in ADVANCED Alternative Payment Models**

Medicare billing charges less than or equal to $30,000 (NOT $10,000)
OR and provides care for 100 or fewer Medicare patients in one year

Note: MIPS does not apply to hospitals or facilities (Part A)
Note: Most clinicians will be subject to MIPS.

- **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 but not have enough payments or patients through the advanced APM to be a QP.

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

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

- Reducing the time and cost to participate
- Providing a transition to help participate through Pick Your Pace
- Increasing opportunities to participate in Advanced APMs
- Conducting Technical Support and outreach to small practices through the forthcoming Quality Payment Program Small, Rural and Underserved Support (QPP-SURS) as well as through the Transforming Clinical Practice Initiative.

- CMS Fact Sheet Where do I go for Help with the Quality Payment Program
MIPS: Pick Your Pace

Don’t Participate  Submit Something  Submit a Partial Year  Submit a Full Year

Positive adjustments are based on performance data on the performance information submitted. Not the amount of information or the length of times submitted.
## Final Rule
### MIPS Data Submission Options
#### Quality and Cost

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Claims</td>
<td>✓ QCDR</td>
</tr>
<tr>
<td>✓ Qualified Clinical Data Registry (QCDR)</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ Qualified Registry</td>
<td>✓ EHR Vendors</td>
</tr>
<tr>
<td>✓ EHR Vendors</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td>✓ CAHPS for MIPS Survey</td>
</tr>
<tr>
<td></td>
<td>✓ Administrative Claims (No submission required)</td>
</tr>
<tr>
<td>No reporting required</td>
<td>No reporting required</td>
</tr>
</tbody>
</table>
## Final Rule
### MIPS Data Submission Options
#### ACI and IA

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Attestation</td>
<td>✓ Attestation</td>
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<tr>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
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<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
</tr>
<tr>
<td>✓ EHR Vendor</td>
<td>✓ EHR Vendor</td>
</tr>
<tr>
<td>✓ CMS Web Interface</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>

- **Advancing care information**
- **IA**
Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

The potential maximum adjustment % will increase each year from 2019 to 2022.
How much can MIPS adjust payments?

**Note:** MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

**Maximum Adjustments**

- 2019: +4%  
- 2020: +5%  
- 2021: +7%  
- 2022 forward: +9%

- 2019: -4%  
- 2020: -5%  
- 2021: -7%  
- 2022 forward: -9%

*Potential for 3X adjustment*
Performance Period

Performance Year (2017)

Submit Performance Data (Deadline March 31, 2018)

Feedback (2018)

Payment Adjustment (Begins January 1, 2019)

Source: https://qpp.cms.gov/
All MIPS performance categories are aligned to a performance period of one full calendar year.

Goes into effect in first year (2017 performance period, 2019 payment year).

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>Payment Year</th>
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<tbody>
<tr>
<td>2017</td>
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<tr>
<td>2018</td>
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<td>2019</td>
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<td>2020</td>
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<td>2022</td>
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<td>2024</td>
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<tr>
<td>2025</td>
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</tbody>
</table>
Final Rule
Percent Contribution to MIPS CPS by Year

*Note: *ACI - The weights for advancing care information could decrease (not below 15 percent) if the Secretary estimates that the proportion of physicians who are meaningful EHR users is 75 percent or greater. The remaining weight would then be reallocated to one or more of the other performance categories.

Federal Register /MACRA Final Rules  p1101
Incentives for Advanced APM Participation
What is an Alternative Payment Model (APM)?

APMs are new approaches to paying for medical care through Medicare that incentivize quality and value.

As defined by MACRA, APMs include:

- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law

MACRA does not change how any particular APM rewards value. APM participants who are not “QPs” will receive favorable scoring under MIPS. Only some of these APMs will be Advanced 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.
Final Rule
Advanced APMs

Current APMs will be Advanced APMs in 2017

✓ Comprehensive ESRD Care (CEC) – Two Sided Risk
  Large dialysis organization (LDO) arrangement
  Non-LDO arrangement
✓ Comprehensive Primary Care Plus (CPC+)
✓ Medicare Shared Savings Program ACOs (Tracks 2 and 3)
✓ Next Generation ACO Model
✓ Oncology Care Model (OCM) (two-sided risk track available in 2018)
In 2018, CMS anticipates the following models will be Advanced APMs:

- ACO Track 1+
- New voluntary bundled payment model
- Comprehensive Care for Joint Replacement Payment Model (Certified Electronic Health Record Technology (CEHRT) track)
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

These lists will continue to change and grow as more models are proposed and developed in partnership with the clinician community and the Physician-Focused Payment Model Technical Advisory Committee.
QPP provides additional rewards for participating in APMs.

**Potential financial rewards**

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments + APM-specific rewards</td>
<td>APM-specific rewards + 5% lump sum bonus</td>
</tr>
</tbody>
</table>

If you are a qualifying APM participant (QP)
How do Eligible Clinicians become Qualifying APM Participants?—Step 1

- Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually.
How do Eligible Clinicians become Qualifying APM Participants?—Step 2

2. CMS will calculate a percentage “Threshold Score” for each Advanced APM Entity using two methods (payment amount and patient count).

- Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM.

- CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

**These definitions are used for calculating Threshold Scores under both methods.**

- **Attributed** (beneficiaries for whose cost and quality of care the APM Entity is responsible)

- **Attribution-eligible** (all beneficiaries who could potentially be attributed)
How do Eligible Clinicians become Qualifying APM Participants?—Step 2

The two methods for calculation are Payment Amount Method and Patient Count Method.

Payment Amount Method

$$$
for Part B professional services to attributed beneficiaries
$$$

$$$
for Part B professional services to attribution-eligible beneficiaries

= Threshold Score %

Patient Count Method

# of attributed beneficiaries given Part B professional services

# of attribution-eligible beneficiaries given Part B professional services

= Threshold Score %
3

The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 and later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Payments through an Advanced APM</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of Patients through an Advanced APM</td>
<td>20%</td>
<td>20%</td>
<td>35%</td>
<td>35%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
How do Eligible Clinicians become Qualifying APM Participants?—Step 4

4 ✓ All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.

Threshold Scores below the QP threshold = no QPs

Threshold Scores above the QP threshold = QP status
### Final Rule
QP Determination and APM Incentive Payment Timeline

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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</thead>
<tbody>
<tr>
<td>QP</td>
<td>QP Performance Period</td>
<td>Incentive Payment Base Period</td>
<td>Payment Year</td>
</tr>
<tr>
<td>Status</td>
<td>QP status based on Advanced APM participation here.</td>
<td>Add up payments for a QP’s services here.</td>
<td>+5% lump sum payment made here. (and excluded from MIPS adjustments)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>QP</td>
<td>QP Performance Period</td>
<td>Incentive Payment Base Period</td>
<td>Payment Year</td>
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<tr>
<td>Status</td>
<td>QP status based on Advanced APM participation here.</td>
<td>Add up payments for a QP’s services here.</td>
<td>+5% lump sum payment made here. (and excluded from MIPS adjustments)</td>
</tr>
</tbody>
</table>

Repeat the cycle each year...
### Putting it all together

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>QP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>Max Adjustment (+/-)</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>+0.5% each year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>Max Adjustment (+/-)</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2020</td>
<td>No change</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>No change</td>
<td>5</td>
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<tr>
<td>2022</td>
<td>No change</td>
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<td>2023</td>
<td>No change</td>
<td>9</td>
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<td>2024</td>
<td>No change</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>No change</td>
<td>9</td>
<td></td>
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<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
Getting Ready to Participate in MIPS

- Determine your eligibility status.
- Determine readiness and choose “how you want to start.”
- Choose if you will be reporting as an individual or group.
- Decide if you will work with a third party intermediary
  - Consider using Qualified Clinical Data Registry (QCDR).
- Choose data submission options.
  - Confirm your EHR is certified.
- Use CMS resources (website) to explore options on measures to use.
Impact on IHS and Tribal Programs

• CMS supports the pursuit of developing Other Payer Advanced APMs under a variety of health care payment programs.

• Payment arrangements not included under Medicare Part B could potentially qualify as Other Payer Advanced APMs for performance periods in 2019 and later.

• IHS, Tribal and Urban Indian health care programs would be eligible for such a designation if they meet the criteria.
## Immediate Action Items

<table>
<thead>
<tr>
<th>#</th>
<th>Immediate Action Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Quality Measure assessment &amp; development / IHS set of eCQMs for reporting</td>
</tr>
<tr>
<td>2</td>
<td>Measures reporting capability (submission from CEHRT or Registry)</td>
</tr>
<tr>
<td>3</td>
<td>Prepare for 2015 CEHRT</td>
</tr>
<tr>
<td>4</td>
<td>Assessment / Development of ACI (MU) measures</td>
</tr>
<tr>
<td>5</td>
<td>Clarify legality of IHS and Tribal participation in MSSP Tracks 2 and 3 and CPC+</td>
</tr>
<tr>
<td>6</td>
<td>Identify pathways for Improvement Activities in MIPS (e.g. PCMH Certified)</td>
</tr>
<tr>
<td>7</td>
<td>Support for I/T/Us in understanding and preparing for Quality Payment Program</td>
</tr>
</tbody>
</table>
QPP / MACRA Next Steps for IHS

• **Identify which Tracks your taking**
  • Can IHS and Tribes participate in advanced APM?
  • MIPS vs. Advanced APM

• **Operationalize the Quality Payment Program**
  • Data Call
  • Crosswalk Measures (eCQM with MIPS)
  • Define Roles and responsibilities
  • Provide Training and education
  • IHS Website and LISTSERV
IHS Website: https://www.ihs.gov/qpp/

LISTSERV Email: MACRA@listserv.ihs.gov
Subscribe URL: https://www.ihs.gov/listserv/topics/signup/?list_id=357
Resources

Centers for Medicare & Medicaid Services. (November 2, 2016) Advanced Alternative Payment Models (APMs) in The Quality Payment Program (slide deck) Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html


Centers for Medicare & Medicaid Services. Quality Payment Program: Modernizing Medicare to provide better care and smarter spending for a healthier America. Available at: https://qpp.cms.gov/


Questions

susy.postal@IHS.gov