Life After PCMH Pilot/ MAPCP: Options for Supporting Alternative Primary Care Payment

7:30 AM – 8:15 AM

Audio available: 1-866-740-1260, Access Code 2520060
Important Webinar Notes

• All lines have been muted

• To ask a question:
  • Use the chat box on the lower left-hand side of the screen
  • Unmute your line - Press *7
    – State your name and Health Home team when speaking
    – Mute your line again - Press *6

• This call will be recorded and shared after the webinar

Dial: 1-866-740-1260
Access Code: 2520060
Dr. Lisa Letourneau serves as Executive Director of Maine Quality Counts, an independent, regional health improvement collaborative committed to transforming health and health care in Maine by leading, collaborating, and aligning improvement efforts. In that role, she helps to support several statewide quality initiatives including the Maine Aligning Forces for Quality initiative, the Maine Patient Centered Medical Home (PCMH) Pilot, and the Choosing Wisely in Maine initiative.
Disclosure Statement

Presenters/Facilitators do not have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.
Learning Objectives

• Identify range of options for alternative payments available to primary care to support PCMH fxns post-PCMH Pilot/ MAPCP demo end (Dec 31, 2016)

• Recognize potential for new payments under CMS fee-for-service codes

• Understand upcoming Medicare payment changes under MACRA/MIPS & identify strategies to maximize MIPS payment incentives &/or minimize payment penalties

• Understand potential changes in health care reform following Nov 8 elections!
What a Difference a Week Makes??

• November 8 election outcomes:
  – Presidential priorities, impact
  – Congressional priorities, impact

• CMS Comprehensive Primary Care (CPC)
  – CPC “original” - (Oct 15) CMS announces positive results for Yr 3 shared savings targets (Oct 15)
  – CPC-Plus: (Oct 28) DHHS announces plans for CPC-Plus expansion – “re-open applications for practices & payers” in 2017, for 2018
Nov Elections: Likely Impact

• Presidential agenda:
  – “Repeal & replace” ACA
  – Enormous pressure to preserve benefits of ACA
    • 20 million Americans currently covered
    • No exclusion for pre-existing condition
  – Other likely changes – e.g. move federal Medicaid funding to state block grants

• Congressional agenda:
  – No indication of MACRA repeal (bipartisan legislation)
  – Some changes in MACRA/QPP rules likely
  – Increasing pressure to control health care costs
  – Support for cont’d primary care payment reform -??
CMS Comprehensive Primary Care (CPC) Initiative

- CMS conception of “PCMH 2.0”
- Aligns Medicare, commercial payers & Medicaid
- Pays primary care risk-adjusted PMPM (avg. $20)
- Offers opportunity for shared savings gainsharing (total cost of care) in Yrs 2, 3, 4
- 2013: CPC “original” started in 7 communities
- 2016: CMS announced “CPC-Plus”; selected 7 more regions for participation, expanded payment model
- Oct 2016: CMS announced plans to expand CPC-Plus in 2017 – opportunity for Maine??
CPC-Plus: What Could it Bring to Maine?

✓ Est’d $50M+ in new Medicare primary care payments
✓ Higher investment in primary care
✓ Continued, exp’d support for practice transformation
✓ Continued commitment to multi-payer approaches to alternative, widespread primary care payment models
✓ More transparent & efficient accountability methods
✓ More patient & community engagement in understanding value of primary care
CPC-Plus: What Would it Take?

• Commercial payer participation!!
  i.e. one or more of...
  – Aetna
  – CIGNA
  – HPHC
  – Community Health Options
• Support from providers
• Support from Maine Medicaid program
• Ultimately, selection by CMS of Maine as addn’l participating region (following payer applications)
Range of Alternative Payment Options Post-Pilot in Maine

- Continued payment of prospective PCMH / care management fees (some commercial payers, MaineCare/HHs)
- Use of newer Medicare FFS codes (e.g. AWV, TCM, CCM, etc)
- Incentive/performance payments (some commercial payers, Medicare /MIPS)
- Distributed “shared savings” funds from successful ACO performance (some commercial payers, MaineCare, Medicare ACOs)
- (Another chance at joining CPC-Plus???)
# Range of Alternative Payment Options Post-Pilot in Maine

<table>
<thead>
<tr>
<th></th>
<th>Commercial Payers</th>
<th>MaineCare</th>
<th>Medicare</th>
<th>Provider ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cont’d prospective PCMH/Care Mngmnt Fees</td>
<td>Some</td>
<td>Yes (HHs)</td>
<td>NO</td>
<td>n/a</td>
</tr>
<tr>
<td>New FFS codes (e.g. AWV, TCM, CCM, ACP)</td>
<td>Some</td>
<td>No</td>
<td>Yes</td>
<td>n/a</td>
</tr>
<tr>
<td>Performance-based incentive payments</td>
<td>Most</td>
<td>No</td>
<td>Yes (QPP/MIPS)</td>
<td>n/a</td>
</tr>
<tr>
<td>Shared savings distributions from ACO contracts</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Yes (potentl)</td>
</tr>
</tbody>
</table>
Continued Payment of Prospective PCMH/Care Management Fees

• Commercial payers:
  – Anthem: Enhanced Personal Health Care initiative
  – Community Health Options: PCMH payments
  – Martins Point Health Plan: PCMH payments
  – Other payers via ACO contracts: variably pay PCMH/care coord payments (not all)

• MaineCare:
  – HH payments for all qualified HH practices
New(er) Medicare Fee for Service Codes

• Welcome to Medicare Visit / Initial Preventive Physical Exam (IPPE)
• Annual Wellness Visit (AWV)
• Transitional Care Management (TCM)
• Chronic Care Management (CCM)
• Advanced Care Planning (ACP)

• New for CY2017 Medicare Physician Fee Schedule:
  – Assessment & care planning for pts with dementia
  – Interprofessional care management / care coordination for pts with BH conditions
# New(er) Medicare Fee for Service Codes & Payments

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
<th>Approx Payment</th>
<th>FQHCs</th>
<th>Comm Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Medicare Visit / Initial Prev Physical Exam (IPPE)</td>
<td>G0402</td>
<td>$156</td>
<td>Yes (?)</td>
<td>n/a</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>G0438</td>
<td>$166</td>
<td>Yes</td>
<td>Varies</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>G0439 (subseqnt)</td>
<td>$111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional Care Management (TCM)</td>
<td>99495 (14d)</td>
<td>$165/$135</td>
<td>Yes</td>
<td>Varies</td>
</tr>
<tr>
<td>Transitional Care Management (TCM)</td>
<td>99496 (7d)</td>
<td>$238/$195</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Care Management (CCM)</td>
<td>99490</td>
<td>$40 pbpm</td>
<td>Yes</td>
<td>Unlikely</td>
</tr>
<tr>
<td>Advance Care Planning (ACP)</td>
<td>99497</td>
<td>$86 $75</td>
<td>Yes</td>
<td>Varies</td>
</tr>
<tr>
<td>Advance Care Planning (ACP)</td>
<td>99498 (addnl 30’)</td>
<td>$86 $75</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MACRA

• Federal law passed in 2015 with broad bipartisan (& organized medicine) support
• Replaced previous (much-hated) Sustainable Growth Formula (SGR), eliminating previous annual scheduled physician fee decreases
• Establishes new payment structure for providers who provide care for Medicare beneficiaries
• Aims to promote Value-Based Payment systems
A Whole New Set of Acronyms...

- **MACRA**: Medicare Access & CHIP Reauthorization Act (passed 2015)
- **QPP**: Quality Payment Program (created by MACRA)
- **MIPS**: Merit-based Incentive Payment System
- **APM**: Alternative Payment Model
- **Advanced APM**: APMs that meet additional criteria for financial risk-bearing
- **ACI**: Advancing Care Information
- **CPIA**: Clinical Performance Improvement Activity
MACRA is part of a broader push towards value and quality.

**Medicare Fee-for-Service**

**GOAL 1:** 30%

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**GOAL 2:** 85%

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.

Department of Health and Human Services 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”
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)
The Quality Payment Program provides **additional** rewards for participating in APMs.

- **Not in APM**: MIPS adjustments
- **In APM**: MIPS adjustments + APM-specific rewards
- **In Advanced APM**: APM-specific rewards + 5% lump sum bonus

If you are a Qualifying APM Participant (QP) = 5% lump sum bonus
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 [OPP.CMS.GOV](https:// OPP.CMS.GOV) and will be updated with new announcements on an ad hoc basis.
What Is MIPS?

Combines legacy programs into single, improved reporting program

PQRS  VM  EHR  MIPS

Legacy Program Phase Out

2016  2018

Last Performance Period  PQRS Payment End
What Is MIPS?

Performance Categories

- Quality
- Cost
- Improvement Activities
- Advancing Care Information

- Reporting standards align with Advanced APMs when possible
- Many measures align with those being used by private insurers
Who Is Eligible for MIPS?

- Medicare Part B clinicians billing more $30,000 and providing care to more than 100 Medicare patients per year.

- Voluntary option for all other clinicians not included in transition year.
Who Is Exempt from MIPS?

- Clinicians who:
  - Are newly enrolled in Medicare
  - Do not meet thresholds:
    - $\leq 30,000$ in Medicare charges
    - OR
    - $\leq 100$ Medicare patients
  - Are significantly participating in an Advanced APM
- MIPS doesn’t apply to hospital-based or facility-based payment programs

Quick Tip: This means than clinicians with $>30,000$ AND $>100$ Medicare patients would be included unless they met other exclusions. The threshold is measured at the group level for group reporting and individual level for individual reporting.
What Are the MIPS Performance Categories?

- Quality
- Improvement Activities
- Advancing Care Information
- Cost
How Are MIPS Performance Categories Weighted?

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

**Transition Year Weights**

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

**NOTE**: These are defaults weights; the weights can adjust in certain circumstances.
MIPS Performance Category: Quality Category Requirements

- Replaces PQRS and Quality Portion of the Value Modifier
- 60% of final score
- Select 6 of about 300 quality measures (minimum of 90 days); 1 must be:
  - Outcome measure OR
  - High-priority measure – defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination
- May also select specialty-specific set of measures
- Readmission measure for group submissions that have > 15 clinicians and a sufficient number of cases (no requirement to submit)
- Different requirements for groups reporting CMS Web Interface or those in MIPS-APMs
How Are MIPS Performance Categories Weighted?

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

Transition Year Weights

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

NOTE: These are defaults weights; the weights can adjust in certain circumstances
MIPS Performance Category: Improvement Activities

- Assesses participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- Clinicians choose from about 90+ activities under 9 subcategories:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response
How Are MIPS Performance Categories Weighted?

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

**Transition Year Weights**

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

NOTE: These are defaults weights; the weights can adjust in certain circumstances.
MIPS Performance Category: Advancing Care Information

- Promotes patient engagement and interoperability using certified EHR technology
- Replaces the Medicare EHR Incentive Program
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  1. Advancing Care Information Objectives and Measures
  2. 2017 Advancing Care Information Transition Objectives and Measures
MIPS Performance Category: Advancing Care Information — Reporting

Clinicians must use certified EHR technology to report

For those using EHR Certified to the 2015 Edition:

Option 1: Advancing Care Information Objectives and Measures

Option 2: Combination of the two measure sets

For those using 2014 Certified EHR Technology:

Option 1: 2017 Advancing Care Information Transition Objectives and Measures

Option 2: Combination of the two measure sets
MIPS Performance Category: Advancing Care Information

<table>
<thead>
<tr>
<th>Advancing Care Information Objectives and Measures</th>
<th>2017 Advancing Care Information Transition Objectives and Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient Electronic Access</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Patient Electronic Access</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Coordination of Care through Patient Engagement</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Coordination of Care through Patient Engagement</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Coordination of Care through Patient Engagement</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Public Health and Clinical Data Registry Reporting</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td><strong>Measure</strong></td>
</tr>
<tr>
<td>Provide Patient Access*</td>
<td>Provide Patient Access*</td>
</tr>
<tr>
<td>Patient-Specific Education</td>
<td>View, Download and Transmit (VDT)</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Secure Messaging</td>
</tr>
<tr>
<td>Patient-Generated Health Data</td>
<td>Patient-Generated Health Data</td>
</tr>
<tr>
<td>Send a Summary of Care*</td>
<td>Send a Summary of Care*</td>
</tr>
<tr>
<td>Request/Accept a Summary of Care*</td>
<td>Request/Accept a Summary of Care*</td>
</tr>
<tr>
<td>Clinical Information Reconciliation</td>
<td>Clinical Information Reconciliation</td>
</tr>
<tr>
<td>Immunization Registry Reporting</td>
<td>Immunization Registry Reporting</td>
</tr>
</tbody>
</table>

* indicates a measure that is required for 2017.
MIPS Vendor Reporting

- Health information technology (HIT) vendors submit data on behalf of clinicians for:
  - Quality
  - Improvement Activities
  - Advancing Care

- If data for activities is derived from CEHRT, vendors must indicate data source and transmit data in a CMS-specified form and manner
How Are MIPS Performance Categories Weighted?

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

Transition Year Weights

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

NOTE: These are defaults weights; the weights can adjust in certain circumstances
MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR), but scoring is different
# When Does MIPS Officially Begin?

<table>
<thead>
<tr>
<th>First Performance Period</th>
<th>First Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2017 through December 31, 2017</td>
<td>2019 Based on 2017 performance</td>
</tr>
</tbody>
</table>
How will the Quality Payment Program change my Medicare payments?

Depending on the data you submit by March 31, 2018, your 2019 Medicare payments will be adjusted up, down, or not at all. The information provided below is only relevant for the 2019 payment year. CMS will provide additional information on payment adjustments for 2020 and beyond beginning next year.

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options.

- **Don’t Participate**: Not participating in the Quality Payment Program:
  If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

- **Submit Something**: Test:
  If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

- **Submit a Partial Year**: Partial:
  If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

- **Submit a Full Year**: Full:
  If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Participate in the Advanced APM path:

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.
Pick Your Pace for Participation for the Transitional Year

Participate in an Advanced Alternative Payment Model

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

Test Pace
- Submit something
- Submit some data after January 1, 2017
- Neutral or small payment adjustment

MIPS
- Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

- Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.
<table>
<thead>
<tr>
<th>Provider Options</th>
<th>Data Submission Requirements</th>
<th>Impact on CY2019 Medicare Payment</th>
<th>New or Existing Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Test QPP</td>
<td>Submit “some” data after Jan 1, 2017</td>
<td>Avoid negative payment adjustment</td>
<td>New</td>
</tr>
<tr>
<td>2. Participate for part of CY2017</td>
<td>Submit data for part of CY2017</td>
<td>Potentially qualify for small positive payment adjustment</td>
<td>New</td>
</tr>
<tr>
<td>3. Participate for full CY2017</td>
<td>Submit data for full CY2017</td>
<td>Potentially qualify for full (up to 4%) positive payment adjustment</td>
<td>Existing</td>
</tr>
<tr>
<td>4. Participate in Advanced APM</td>
<td>(Advanced APM data requirements)</td>
<td>5% payment adjustment for Qualified Providers</td>
<td>Existing</td>
</tr>
</tbody>
</table>
Significant Payment Implications!

• Even small provider practice, could see penalties (or bonuses) of tens – thousands $$ per year
• Impacts each provider’s overall Medicare payments
• Payments are required to be budget neutral, with high (bonuses) & low (penalty) scores defined as > 1 Standard Deviation above or below mean
• Consider using MIPS payment calculators to assess impact on your practice – e.g.
  – http://njii.com/mips-calculator/
  – http://www.saignite.com/resources/mips-calculator
How much can MIPS adjust payments?

Based on a CPS, clinicians will receive +/- or neutral adjustments up to the percentages below.

Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022.
Estimated MIPS Impact by Practice Size

% With Positive or Negative MIPS Adjustment

-100% -100%
-80% -80%
-60% -60%
-40% -40%
-20% -20%
0% 0%
20% 20%
40% 40%
60% 60%
80% 80%
100% 100%

All Clinicians
Solo
2-9 clinicians
10-24 clinicians
25-99 clinicians
100 or more clinicians

-100% -100%
-80% -80%
-60% -60%
-40% -40%
-20% -20%
0% 0%
20% 20%
40% 40%
60% 60%
80% 80%
100% 100%
QPP/MIPS: Key Steps for Maine Clinicians

1. Act now to educate yourself – don’t wait!
   - CMS: https://qpp.cms.gov/
   - QC: https://www.mainequalitycounts.org/page/950-1505/value-based-payment
   - AMA, ACP, AAFP, others...

2. Engage with other clinicians & practice staff; connect with local & regional ACO and provider group leaders (small practices projected to be more at risk for penalties!)

3. Identify staff lead responsible for both quality & EMR reporting

4. Use available tech assistance resources – e.g. QIN
How QC Can Help!

• Use local educational resources – e.g.
  – QC webinars, website, newsletter
  – QIN webinars, website, newsletter

• If eligible, consider participation in NNE-PTN
  – No-cost assistance with PQRS reporting!

• Participate in QC clinical quality improvement activities (CPIA credit!)

• Consider reporting MIPS measures through Mingle-QC Qualified Clinical Data Registry (QCDR)
The Quality Payment Program Service Center is also available to help:

qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program’s 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

If you’re in an APM: The Innovation Center’s Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you’re in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model’s support inbox.
https://qpp.cms.gov/
What’s the Merit-based Incentive Payment System (MIPS)?

If you decide to participate in traditional Medicare Part B, rather than an Advanced APM, then you will participate in MIPS where you earn a performance-based payment adjustment to your Medicare payment.

How does MIPS work?

You earn a payment adjustment based on evidence-based and practice-specific quality data. You show you provided high quality, efficient care supported by technology by sending in information in the following categories.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS.</td>
<td>New category.</td>
<td>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</td>
<td>Replaces the Value-Based Modifier.</td>
</tr>
</tbody>
</table>

The cost category will be calculated in 2017, but will not be used to determine your payment adjustment. In 2018, we will start using the cost category to determine your payment adjustment.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2017</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>
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.

**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.

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

- **Quality Payment Program Website**: 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.
  1-866-288-8292  TTY: 1-877-715-6222  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.
New England QIN Resources & TA

• QIN available to provide assistance to all Maine practices with QPP implementation

• Dedicated webpage:
  – Making Sense of MACRA: Quality Payment Program

• Educational webinars
  – Open Call on QPP & MIPS

• Offering “MIPS/APMS Boot Camp” with baseline assessment tool & coaching
New England QIN “Boot Camp” Baseline Assessment Tool

### General
- I am a solo practitioner
- I am part of a group* for providers
  - Practice size (# of providers): ________________
- Patient panel size:
- I see <100 Medicare part B beneficiaries annually
- I submit < $30,000 in Medicare claims annually
- This is my first year submit Medicare claims

### Reporting And Practice Improvement
- I belong to an Accountable Care Organization (ACO)
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation
- I joined Comprehensive Primary Care Plus (CPC+)
- I joined the Transforming Clinical Practice Initiative (TCPI)
- I am a Patient-Centered Medical Home (PCMH)
- I practice in a rural area

### Education - Learning Modules
- I have reviewed/utilized the CMS-provided learning modules on MACRA/MIPS/APMs (CME/CEU offered)
- Date completed:
- I would like assistance with understanding MIPS scoring

### Population Health
- I am involved in chronic disease management activities

### Physician Quality Reporting System (PQRS)
- I participated as an individual for program year 2015
  - Reporting method:
    - EHR Direct
    - Registry
    - CMS Portal via QRDA
- I participated as part of a group for program year 2015
- Registration for Group Reporting Option (GPRO) for 2016 has been completed
- Reporting type: ________________
- I did not attest for PQRS in 2015

### Quality Resource Use Reports (QRUR)
- I have reviewed my 2015 annual QRUR
- I would like assistance interpreting my 2015 annual QRUR
- I would like assistance downloading/my 2015 annual QRUR

### Practice Claims and Revenue
- My practice submits claims for:
  - Medicare Annual Wellness visits
  - Chronic Care Management visits
  - Transitional Care Management visits

### Meaningful Use (MU)
- I successfully attested for program year 2015:
  - Stage 1
  - Stage 2
  - Stage 2 Modified
  - Reporting method:
    - EHR Direct
    - Registry
    - CMS Portal via QRDA
- Certified EHR system is currently in place
  - Vendor, Version: ________________
- Workflows support clinical quality measures
- Security risk assessment has been completed and incorporated into workflow
- Actively engage patients via the patient portal
- Currently connected to the HIE
- Report immunizations or other public health data to the appropriate state registry
  - If I did not attest for MU in 2015:
    - Plans are in place to upgrade to or implement a certified EHR system
      - Vendor, Version: ________________
    - Review performance on clinical quality measures
    - Plan in place to identify workflows to support reporting needs
    - Request assistance in evaluating workflows
    - Complete security risk assessment
    - Establish connection with the HIE

### Quality and Improvement Activities
I have determined the 6 quality measures I plan to report
1. ________________
2. ________________
3. ________________
4. ________________
5. ________________
6. ________________

Outcome measure is:

2. I have identified the improvement activities I plan to complete (1 to 4 measures)
   1. Work with the New England QIN-Q/O on ...
      - Population health management, patient self-management training, technical assistance activities
   2. ________________
   3. ________________
   4. ________________
   5. ________________
   6. ________________

Please send completed Readiness Assessment to:
Rachel Crowe – rcrowe@healthcentricadvisors.org
Beyond the Pilot: Still Need...

- More substantial, widespread, and sustained payment change for primary care
- Commitment to multi-payer approaches to alternative primary care payment models
- Higher investment in primary care (set target for primary care % spend of total health care costs)
- More linking of practice transformation with payment reform
- More efficient accountability methods
Contact Info / Questions

- Lisa Tuttle MPH, Program Director, Practice Transformation
  - LTuttle@mainequalitycounts.org
  - Tel. 207.620.8526, 1015

- Joan Orr, Program Director, NNE-PTN
  - Tel. 207.620.8526, 1039
  - NNE-PTN webpage

- CMS MACRA – MIPS & Quality Payment Program
  - https://qpp.cms.gov/

- New England QIN
  - http://www.healthcarefornewengland.org/
  - Rachel Crowe MPH, BSN, RN, Program Coordinator, QPP
    - rcrowe@healthcentricadvisors.org
    - Tel. 207.406.3980
Save the Date

December 2, 2016

PCMH Pilot Celebration

Maple Hill Farms
Hallowell, Maine
Want to share with your team?

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Contact Info/Questions for PCMH/Health Home Practices

General Questions: Health_Homes@mainequalitycounts.org

Practice Facilitators:

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