National Quality Forum Conference

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Agenda

- Delivery System Reform and Results to Date
- Quality Payment Program and Measure Development
- Partnership between CMS and NQF

A Value-Based System requires focusing on how we pay providers, deliver care, and distribute information

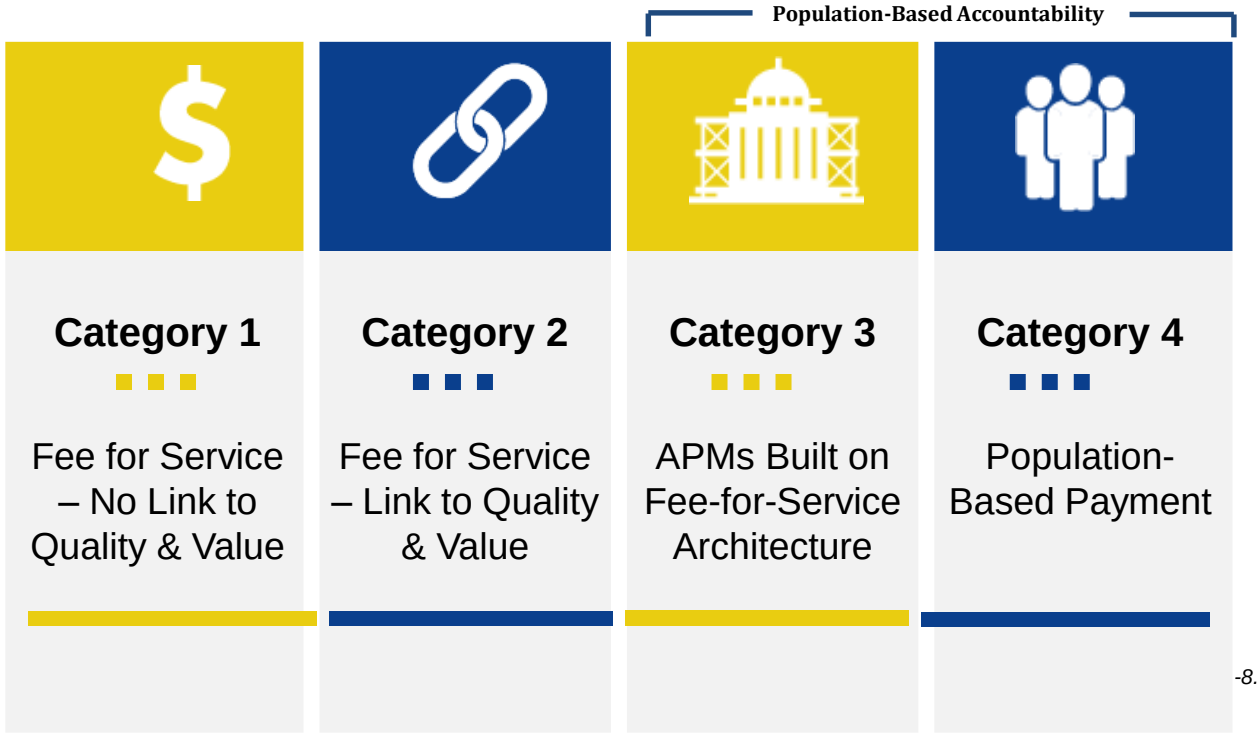
Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

FOCUS AREAS

- **Pay Providers**
- **Deliver Care**
- **Distribute Information**

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

CMS has adopted a framework that categorizes payment to providers



MARCH 2016

HHS announced that goal of 30% payments tied to quality through APMs achieved one year ahead of schedule!

Medicare Fee-for Service

GOAL: 30%

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016

Next

1. **Testing of new models and expansion of existing models**
2. **Health Care Payment Learning and Action Network**

CMS established large-scale, action-oriented networks to spread quality improvement and safety activities on a national scale

Partnership for Patients

- 4,000 Hospitals

Transforming Clinical Practices Initiative

- 140,000 Clinicians

End Stage Renal Disease Networks

- 6,000 Dialysis Facilities

Quality Innovation Networks – Quality Improvement Organizations

- 250+ Communities
- 10,000+ Nursing Homes
- 3,800 Home Health Organizations
- 300 Hospices
- 1,700 Pharmacies

MACRA and Quality Payment Program - Small, Underserved, Rural Support

- Up to 200,000 Clinicians

National Results on Patient Safety Substantial progress thru 2015, compared to 2010 baseline

- **21 percent** decline in overall harm
- **125,000 lives saved**
- **$28B in cost savings** from harms avoided
- **3.1M fewer harms** over 5 years
- Think about what these means for so many **patients and families**

Source: Agency for Healthcare Research & Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update. Interim Data from National Efforts to Make Care Safer, 2010 – 2014." December 1, 2015

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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 Alternate 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.

Quality Payment Program Strategic Goals

Improve beneficiary outcomes	Enhance clinician experience
Increase adoption of Advanced APMs	Maximize participation
Improve data and information sharing	Ensure operational excellence in program implementation

Quick Tip:
For additional information on the Quality Payment Program, please visit QPP.CMS.GOV

What is the Merit-based Incentive Payment System?

Performance Categories

Quality

Cost

Improvement Activities

Advancing Care Information

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

Advanced Alternative Payment Models

Clinicians and practices can:

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

Advanced APMs →  + 

Advanced APM-specific rewards

5% lump sum incentive

"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.

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.

Future Advanced APM Opportunities

In future performance years, we anticipate that the following models will be Advanced APMs:

- Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
- New Voluntary Bundled Payment Model
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- ACO Track 1+

Keep in mind: The Physician-Focused Payment Model Technical Advisory Committee (PTAC) will review and assess proposals for Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

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Where can I go to learn more?

qpp.cms.gov

Future of our health system

- Alternative Payment Models
  - ACOs
  - Comprehensive Primary Care
  - Physician-focused APMs
- Private payer and CMS collaboration critical
- States and Communities driving innovation and delivery system reform
- Increasing integration of public health and population health with health care delivery system
- Patient-centered, coordinated care is the norm
- Focus on quality and outcomes

CMS Quality Measure Development Plan

- Required under MACRA to set priorities for MIPS and APMs
- Initially focuses on measure gaps identified in the CMS portfolio of quality measures
- Over 80% of MIPS measures are for specialists, but gaps remain
- Recommends prioritized approaches to close gaps through the development, adoption, and refinement of quality measures
- Sets expectations for CMS-funded measure developers
- Make progress on the data infrastructure for QM development (data elements, testing)
- Makes available technical and subject matter expertise to clinician organizations

Priorities for Measure Development

- Outcome and Patient-reported Outcome Measures
- Cross-cutting measures (patients with MCCs)
- Focused measures for specialties that have clear gaps
  - Palliative care, oncology, orthopedics

- Measures of diagnostic accuracy
- Novel and real-time ways to measure patient experience (mobile technology, e.g.)
- Appropriate Use of technology, services
- Episode based resource use

Challenges

- Defining the right outcome/performance gap
- Engaging patients and front-line clinicians in the measure development process
- Advancing the science for critical measure types: PROMs, resource use, appropriate use, etc.
- Robust feasibility, reliability and validity testing
- Reduction of provider burden and cost to reporting measures
- Cycle time and cost to develop measures

The Importance of the NQF/ CMS Partnership

NQF and CMS

- Measure endorsement
- Development of the measurement science
- Multi-stakeholder review of measures for CMS programs
- Collaboration on feedback loops
- Continuous improvement

NQF's Measure Application Partnership (MAP)

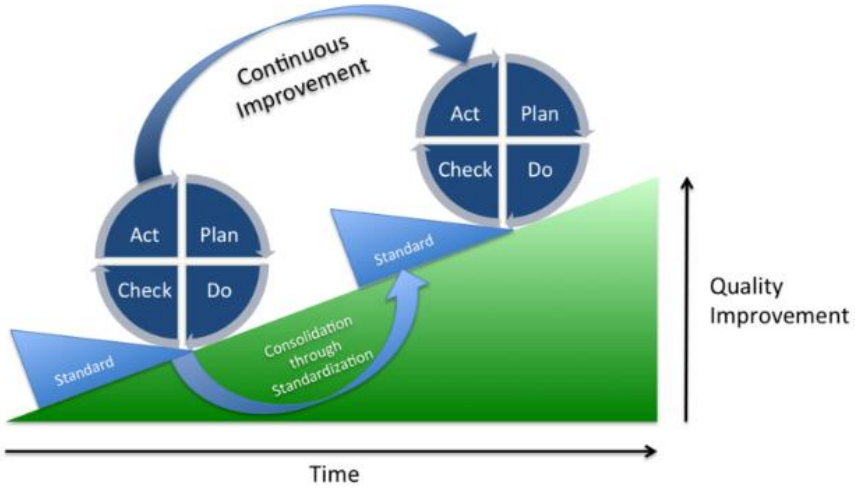
- MAP is a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.
- Congress recognized the benefit of an approach that encourages consensus building among diverse private- and public-sector stakeholders.
- The MAP provides a coordinated look across federal programs at performance measures being considered

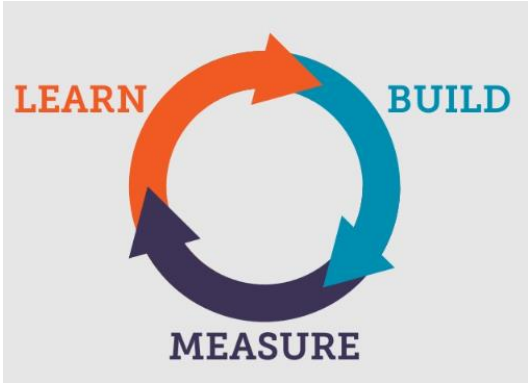
Pre-rulemaking Process: Measure Selection

- The Pre-rulemaking Process – provides for more formalized and thoughtful process for considering measure adoption:
- Early public preview of potential measures
- Multi-stakeholder groups seek feedback and consider prior to rulemaking
- Review measures for alignment and to fill measurement gaps prior to rulemaking
- Endorsement status considered favorable; lack of endorsement must be justified for adoption.
- Potential impact of new measures and actual impact of implemented measures considered in selection determination (feedback loop)

Partnership in Continuous Improvement

NQF and CMS must work together to streamline, reduce cost and cycle time, establish feedback loops and integrate endorsement and multi-stakeholder input





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