Conflict of Interest

Robert Anthony
Has no real or apparent conflicts of interest to report.
Learning Objectives

• Assess the current readiness of your organization to comply with MIPS reporting requirements.
• Describe current and future requirements for quality reporting eMeasures to CMS for the Meaningful Use, IQR, PQRS, and MIPS programs.
• Develop an action plan for transitioning from attestation to eReporting in 2016.
Working Toward Value and Quality

The CMS Quality Strategy guides the activities of all agency components working together toward health care transformation.

The Strategy:

✓ Builds on the foundation of the CMS Strategy and the HHS National Quality Strategy (NQS).
✓ Prioritizes six goals for success.
✓ Illustrates continued collaboration through a participatory, transparent and collaborative process with a wide array of stakeholders.
The 2016 CMS Quality Strategy Mission

Optimize health outcomes by leading clinical quality improvement and health system transformation.
CMS Quality Strategy Aims and Goals

- **Goal 1**: Make care safer by reducing harm caused in the delivery of care.
- **Goal 2**: Strengthen person & family engagement as partners in their care.
- **Goal 3**: Promote effective communication & coordination of care.
- **Goal 4**: Promote effective prevention & treatment of chronic disease.
- **Goal 5**: Work with communities to promote best practices of healthy living.
- **Goal 6**: Make care affordable.

- **Better Care**
- **Healthier People, Healthier Communities**
- **Smarter Spending**
CMS Quality Strategy Goals and Foundational Principles

Foundational Principles:
- Eliminate Racial & Ethnic Disparities
- Strengthen Infrastructure & Data Systems
- Enable Local Innovations
- Foster Learning Organizations

1. Make care safer by reducing harm caused in the delivery of care.
2. Strengthen person & family engagement as partners in their care.
3. Promote effective communication & coordination of care.
5. Work with communities to promote best practices of healthy living.
Administration’s Goals for Payment Reform

Goal #1

- 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016, and 50% by the end of 2018

Goal #2

- 85% of all Medicare FFS payments are tied to quality or value by the end of 2016, and 90% by the end of 2018
CMS Quality Strategy Goals and Objectives

Advancing Our Three Aims
Goal 1: Make Care Safer by Reducing Harm Caused in Delivery of Care

Strategic Result: Healthcare-related harms are reduced

• Background:
  • Healthcare-related errors harm millions of Americans each year and add billions of dollars to healthcare costs.
  • Two prominent examples include healthcare-associated infections and adverse medication events.
Goal 1: Make Care Safer by Reducing Harm Caused in Delivery of Care

Improve support for a culture of safety

Reduce inappropriate and unnecessary care that can lead to harm

Prevent or minimize harm in all settings
Goal 1: Make Care Safer by Reducing Harm Caused in Delivery of Care

CMS aims to achieve the objectives by:

✓ Improving communication among patients, families, and providers;

✓ Empowering patients to become more engaged in their care;

✓ Promoting better coordination of care within and across settings;

✓ Implementing evidence-based safety best practices wherever care is provided; and

✓ Supporting payment systems that incentivize smarter use of tests and treatments to minimize harm from inappropriate care.
Goal 1: Make Care Safer by Reducing Harm Caused in Delivery of Care

CMS programs and initiatives to help transform health care and support the goal and objectives:

- Providing financial incentives to reward providers for adopting best practices that can decrease harm.
- Offering providers the opportunity to work together.
- Assuring patients’ safety through its survey and certification authority by assessing compliance with federal health and safety-related standards, including those related to quality assessment and performance improvement.
- Partnering with healthcare providers to transform and create a system that reliably provides high-quality healthcare for everyone.
Goal 2: Strengthen Person and Family Engagement as Partners in Their Care

Strategic Result: Persons and families are engaged as informed, empowered partners in care.

Background:

• Studies have found that person-centered care models improve quality of care and health outcomes, engage people more actively in their healthcare, and can reduce costs and disparities in care.

• A person-centered approach demands that providers and individuals share power and responsibility in goal setting, decision-making, and care management.
Goal 2: Strengthen Person and Family Engagement as Partners in Their Care

Ensure all care delivery incorporates person and family preferences

Improve experience of care for persons and families

Promote self-management
Goal 2: Strengthen Person and Family Engagement as Partners in Their Care

CMS aims to achieve the objectives by:

✓ Actively encouraging person and family engagement across the care continuum;

✓ Promoting tools and strategies that promote self-determination and achieve individuals’ goals, values, and preferences;

✓ Creating an environment where the individual, as the center of the healthcare team, can create health and wellness goals that are accessible, appropriate, effective, and sufficient; and

✓ Developing criteria to identify person and family engagement best practices and techniques ready for widespread integration and scaling to improve the experience of care for individuals and families.
Goal 2: Strengthen Person and Family Engagement as Partners in Their Care

CMS is at the forefront of the nationwide effort to transform healthcare delivery to meet individuals’ person-centered goals through its Quality Improvement Organization initiatives:

- *Everyone with Diabetes Counts* program
- Experience of care surveys
Goal 3: Promote Effective Communication and Coordination of Care

Strategic Result: Communication, care coordination, and satisfaction with care are improved.

Background:

- Poor coordination of healthcare can result in harms to healthcare patients and increase costs.
- Most healthcare payment systems pay for volume over value, and do not foster coordination of care or understanding of patient preferences.
- Rewarding providers for doing more, rather than for working together, compromises the ability to achieve the best outcomes for individuals and communities.
Goal 3: Promote Effective Communication and Coordination of Care

- Reduce admissions and readmissions
- Embed best practices to enable successful transitions between all settings of care
- Enable effective healthcare system navigation
Goal 3: Promote Effective Communication and Coordination of Care

CMS aims to achieve the objectives by:

- Encouraging care coordination across the healthcare continuum;
- Promoting a person-centered approach to coordination of care; and
- Recognizing the positive impact of having critical pieces of information communicated across all providers and settings of care.
Goal 3: Promote Effective Communication and Coordination of Care

CMS programs and initiatives to help transform health care and support the goal and objectives:

• Strengthening hospital Conditions of Participation (CoP) for Discharge Planning to require more robust communication between acute and post-acute care settings
• HHS’s Partnership for Patients initiative
• The Electronic Health Record (EHR) Incentives Program
• The 11th Scope of Work for CMS’s Quality Innovation Network/Quality Improvement Organizations
Goal 4: Promote Effective Prevention and Treatment of Chronic Disease

Strategic Result: Leading causes of mortality are reduced and prevented.

Background:

- Chronic conditions last a year or more and require ongoing medical attention and/or limit activities of daily living.
- More than 133 million Americans report at least one chronic condition, while many have multiple chronic conditions (MCC)—two or more chronic conditions that affect a person at the same time.
- Increased spending on chronic conditions among Medicare beneficiaries is a key factor driving the overall increase in spending in the traditional Medicare program.
Goal 4: Promote Effective Prevention and Treatment of Chronic Disease

Increase appropriate use of screening and prevention services

Strengthen interventions to prevent heart attacks and strokes

Improve quality of care for people with multiple chronic conditions

Improve behavioral health (BH) access and quality care

Improve perinatal outcomes
Goal 4: Promote Effective Prevention and Treatment of Chronic Disease

CMS aims to achieve the goal and objectives by:

- Collaborating with providers, states, partner agencies, and stakeholder groups to increase awareness of current and new preventive healthcare services available to Medicare, Medicaid, and CHIP beneficiaries;

- Raising the profile of identified preventive services that will have the greatest impact on improving beneficiary health; and

- Reducing disparities in access to and utilization of primary and specialty healthcare, preventive services for all populations.
Goal 4: Promote Effective Prevention and Treatment of Chronic Disease

CMS has incorporated prevention measures in our quality reporting programs, including:

- The Million Hearts® initiative
- Surviving Sepsis campaign
- Healthy People 2020
- Health Homes*
- Adult Medicaid Core Set of Quality Measures*
- Program for All-inclusive Care for the Elderly (PACE)*
Goal 5: Work with Communities to Promote Best Practices of Healthy Living

*Strategic Result: Best practices are promoted, disseminated, and used in communities.*

**Background:**

- Many factors influence health and well-being, including individual behavior, access to health services, and the environments where people live.
- Efforts to improve lives through access to appropriate healthcare rely on deploying evidence-based interventions and strong partnerships among local healthcare providers, public health professionals, community and social service agencies, and individuals.
Goal 5: Work with Communities to Promote Best Practices of Healthy Living

Partner with and support federal, state, and local public health improvement efforts

Improve access within communities to best practices of healthy living

Promote evidence-based community interventions to prevent and treat chronic disease

Increase use of community-based social services and HCBS
Goal 5: Work with Communities to Promote Best Practices of Healthy Living

CMS aims to achieve the goal and objectives by:

- Building and strengthening relationships with all partners to better link Medicare, Medicaid, and CHIP beneficiaries, and the providers that serve them, with communities and resources that support good health.

- Encouraging providers to partner with local and state public health improvement efforts so that Medicaid, Medicare, and CHIP beneficiaries can benefit from the high-quality community-based programs and services that support healthy living.
Goal 5: Work with Communities to Promote Best Practices of Healthy Living

Some current federal efforts to promote healthy living and healthy communities include:

- Let’s Move!
- Safe Routes to School National Partnership
- CDC: Communities Putting Prevention to Work
- CDC: Community Transformation Grants program
- WIC Farmers’ Market Nutrition Program/U.S. Department of Agriculture Senior Farmers’ Market Nutrition Program
- The Surgeon General’s National Prevention Strategy
- The Surgeon General’s Call to Action to Promote Healthy Homes
- The White House’s Neighborhood Revitalization Initiative
- The Program for All-inclusive Care for the Elderly
Goal 6: Make Care Affordable

Strategic Result: Quality care is affordable for individuals, families, employers, and governments.

Background:

- Despite the decrease in the growth rate of spending, the cost of medical care remains unacceptably high.
- Higher costs lead to underutilization of appropriate care and services, greater financial burden on the sickest and most vulnerable, and increased burden on providers and payers.
Goal 6: Make Care Affordable

Develop and implement payment systems that reward value over volume

Use cost analysis data to inform payment policies
Goal 6: Make Care Affordable

As the largest payer of healthcare in the United States, CMS has the ability to drive change and transform the healthcare system to reward high-value care by:

- Establishing common measures that will help assess the cost impact of new programs and payment systems;
- Improving data systems by encouraging and supporting health information exchanges for administrative simplification, and making data available to providers;
- Making healthcare costs and quality more transparent to consumers and providers, enabling them to make better choices and decisions;
- Implementing national quality improvement programs and initiatives to systematically spread known best practices to reduce costs and improve care.
Goal 6: Make Care Affordable

CMS programs and initiatives to transform health care and support the goal and objectives:

• The Medicare Shared Savings Program promotes the goal of reducing growth in expenditures for Medicare fee-for-service beneficiaries.

• The Hospital Value-Based Purchasing Program adjusts hospital payments made by Medicare for inpatient services based on their performance on measures that fall into a number of domains, including patient safety, clinical outcomes, and patient experience.

• The new Merit-based Incentive Payment System and the transition of clinicians to Alternative Payment Models, as called for by the MACRA legislation, supports and reinforces the transformation of payment to clinicians based on value.
The Future: Merit-Based Incentive Payment System (MIPS)

Shifting Medicare Reimbursements from Volume to Value
MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare:

**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

**STAKEHOLDERS:**
Consumers | Businesses
Payers | Providers
State Partners

**Set internal goals for HHS**

**Invite private sector payers to match or exceed HHS goals**
MACRA 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% payments linked to quality and value (Categories 2-4)
- **2018**
  - 50% payments linked to quality and value via APMs (Categories 3-4)

**Medicare payments to those in the most highly advanced APMs under MACRA**

**Categories 1-4**

- All Medicare fee-for-service (FFS) payments
- Medicare FFS payments linked to quality and value
- Medicare payments linked to quality and value via APMs

**Categories 3-4**

- Medicare-Payments to those in the most highly advanced APMs under MACRA
3 goals for our health care system:

**BETTER** care  
**SMARTER** spending  
**HEALTHIER** people

Via a focus on 3 areas:

- Incentives
- Care Delivery
- Information Sharing
What is “MACRA”? 

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

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible** alternative payment models (APMs)
Through MACRA, HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician’s or practitioner’s status with respect to MIPS and/or APMs.
- Support **multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.
MIPS changes how Medicare links performance to payment

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

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

MACRA streamlines those programs into **MIPS**:

- **Merit-Based Incentive Payment System (MIPS)**
MIPS changes how Medicare links performance to payment

- Applies to individual EPs, groups of EPs or virtual groups
- 2019 & 2020 (First two years)
  - Physicians, PAs
  - Certified Registered Nurse Anesthetists
  - NPs, Clinical Nurse Specialists
  - Groups that include such professionals
- 2021 onward
  - Secretary can add EPs (described in 1848(k)(3)(B)) to MIPS
- Excluded EPs
  - Qualifying APM participants
  - Partial Qualifying APM Participants
  - Low volume threshold exclusions
More on MIPS

Beginning Jan 1, 2019

• CMS must assess performance based on performance standards during a performance period for measures and activities in the following 4 performance categories.

• A composite or total performance score will be developed using a scoring scale of 0 to 100.

• The weights for each category are indicated below.

Performance Categories

– Quality measures (30 percent of Score)

– Resource Use measures (30 percent of Score)
  • Counts for not more than 10 percent in 2019 and 15 percent in 2020; additional weight of at least 20 percent and 15 percent, respectively, are added to the Quality score in those years

– Clinical Practice Improvement Activities (15 percent of Score)
  • Sub-Categories- Includes Better Off-Hours Access, Care Coordination
  • Patient Safety, Beneficiary Engagement
  • Others as Determined by Secretary

– Meaningful Use of EHRs (25 percent of Score)
How Will Physicians and Practitioners Be Scored Under MIPS?

A single MIPS composite performance score will factor in performance in **4 weighted performance categories:**

- Quality
- Resource use
- Clinical practice improvement activities
- Meaningful use of certified EHR technology

MIPS Composite Performance Score
The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

- Secretary shall solicit suggestions from stakeholders to identify activities.
- Secretary shall give consideration to practices <15 EPs, rural practices, and EPs in underserved areas.

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
<th>Beneficiary Engagement</th>
<th>Patient Safety Practice Assessment</th>
<th>Alternative Payment Models</th>
</tr>
</thead>
</table>
| • Same day appointments for urgent needs  
  • After hours clinician advice | • Monitoring health conditions & providing timely intervention  
  • Participation in a qualified clinical data registry | • Timely communication of test results  
  • Timely exchange of clinical information with patients AND providers  
  • Use of remote monitoring  
  • Use of telehealth | • Establishing care plans for complex patients  
  • Beneficiary self-management assessment & training  
  • Employing shared decision making | • Use of clinical checklists  
  • Use of surgical checklists  
  • Assessments related to maintaining of certification | • Participation in an APM will also count for CPIA |
MIPS Performance Categories

Weighted Performance Categories

- Quality Measures: 25%
- Resource Use: 30%
- Clinical Practice Improvement Activities: 15%
- Meaningful Use of EHRs: 30%
MIPS Composite Performance Score:

- Performance assessment in four categories using weights established in the statute
- Weights may be adjusted if there are not sufficient measures and activities applicable for each type of EP, including assigning a scoring weight of 0 for a performance category.
- EHR weighting can be decreased and shifted to other categories if Secretary estimates the proportion of physicians who are meaningful EHR users is 75% or greater (statutory floor for EHR weight is 15%)
- **Performance threshold** will be established based on the mean or median of the composite performance scores during a prior period
- The composite performance score will range from 0 – 100
- The score will assess achievement & improvement (when data available)
How much can MIPS adjust payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral. A scaling factor may be applied to upward adjustments to make total upward and downward adjustments equal.

<table>
<thead>
<tr>
<th>Year</th>
<th>Maximum Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4%</td>
</tr>
<tr>
<td>2020</td>
<td>-5%</td>
</tr>
<tr>
<td>2021</td>
<td>-7%</td>
</tr>
<tr>
<td>2022 onward</td>
<td>-9%</td>
</tr>
</tbody>
</table>

*MACRA allows potential 3x upward adjustment BUT unlikely
More on MIPS

To implement MIPS, CMS will:

• Make available timely ("such as quarterly") confidential feedback reports to each MIPS EP starting July 1, 2017.

• Provide information about items and services furnished to the EP’s patients by other providers and suppliers for which payment is made under Medicare to each MIPS EP, beginning July 1, 2018.

• Make information about the performance of MIPS EPs available on Physician Compare.
Are there any exceptions to MIPS adjustments?

There are 3 groups of physicians and practitioners who will NOT be subject to MIPS:

1. **FIRST year of Medicare participation**

2. Participants in eligible Alternative Payment Models who qualify for the bonus payment

3. Below low volume threshold

Note: MIPS does not apply to hospitals or facilities
Potential value-based financial rewards

- APMs—and eligible APMs in particular—offer greater potential risks and rewards than MIPS.
- In addition to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

<table>
<thead>
<tr>
<th>MIPS only</th>
<th>APMs</th>
<th>eligible APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>APM-specific rewards + MIPS adjustments</td>
<td>eligible APM-specific rewards + 5% lump sum bonus</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>------</td>
</tr>
<tr>
<td>Physician Fee Schedule Updates</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>0.25 N-QAPMCF**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MIPS**

- Quality: 4%, 5%, 7%, 9%
- Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of Certified EHR Technology

**APMs**

- Qualifying APM Participant
- Excluded from MIPS

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
What should I do to prepare for MACRA?

✓ Look for future educational activities

✓ Look for a proposed rule in spring 2016 and provide comments on the proposals.

✓ Final rule targeted for early fall 2016.
Questions?
# Join CMS Sessions at HIMSS16

<table>
<thead>
<tr>
<th>Title</th>
<th>Session</th>
<th>Time &amp; Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tuesday, March 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS EHR Incentive Programs in 2015 through 2017 Overview</td>
<td>26</td>
<td>10:00 a.m. – 11:00 a.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palazzo B</td>
</tr>
<tr>
<td>CMS Listening Session: EHR Incentive Programs in 2018 &amp; Beyond</td>
<td>56</td>
<td>1:00 p.m. – 2:00 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palazzo B</td>
</tr>
<tr>
<td>A Special Session with ONC and CMS (Presentation by Dr. Karen DeSalvo and Andy Slavitt)</td>
<td>N/A</td>
<td>5:30 p.m. – 6:30 p.m.</td>
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<tr>
<td></td>
<td></td>
<td>Rock of Ages Theatre</td>
</tr>
<tr>
<td><strong>Wednesday, March 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS Listening Session: Merit-Based Incentive Payment System (MIPS)</td>
<td>101</td>
<td>8:30 a.m. – 9:30 a.m.</td>
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<tr>
<td></td>
<td></td>
<td>Palazzo B</td>
</tr>
<tr>
<td>CMS Electronic Clinical Quality Measurement (eCQM) Development and Reporting</td>
<td>131</td>
<td>11:30 a.m. – 12:30 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palazzo B</td>
</tr>
<tr>
<td><strong>Thursday, March 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interoperability Showcase: eCQM Submissions</td>
<td>N/A</td>
<td>10:00 a.m. – 11:00 a.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Booth #11954</td>
</tr>
<tr>
<td>CMS Person and Family Engagement: Incentivizing Advances that Matter to Consumers</td>
<td>234</td>
<td>1:00 p.m. – 2:00 p.m.</td>
</tr>
<tr>
<td></td>
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<td>Palazzo B</td>
</tr>
<tr>
<td>Office Hours Topic</td>
<td>Time</td>
<td></td>
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<tr>
<td>--------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>Tuesday, March 1</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Merit-Based Incentive Payment System (MIPS)             | 11:30 a.m. – 12:30 p.m.  
Booth #10309                                            |
| Quality Measurement Development and Reporting           | 12:30 p.m. – 1:30 p.m.  
Booth #10309                                            |
| EHR Incentive Programs                                 | 2:30 p.m. – 3:30 p.m.  
Booth #10309                                            |
| **Wednesday, March 2**                                 |                    |
| Merit-Based Incentive Payment System (MIPS)             | 10:00 a.m. – 11:00 a.m.  
Booth #10309                                            |
| EHR Incentive Programs                                 | 11:00 a.m. – 12:00 p.m.  
Booth #10309                                            |
| Quality Measurement Development and Reporting           | 2:00 p.m. – 3:00 p.m.  
Booth #10309                                            |
| **Thursday, March 3**                                  |                    |
| Merit-Based Incentive Payment System (MIPS)             | 9:30 a.m. – 10:30 a.m.  
Booth #10309                                            |
| EHR Incentive Programs                                 | 11:00 a.m. – 12:00 p.m.  
Booth #10309                                            |
| Quality Measurement Development and Reporting           | 1:00 p.m. – 2:00 p.m.  
Booth #10309                                            |