Conflict of Interest

Daniel F. Gottlieb, Esq., is a partner of McDermott Will & Emery LLP, a large international law firm which represents numerous vendors, suppliers and providers of health care items and services.

Scott A. Weinstein, Esq., is an associate at McDermott Will & Emery LLP, a large international law firm which represents numerous vendors, suppliers and providers of health care items and services.
Agenda

• Introductions

• Future of Quality Reporting and Value-Based Payment

• Quality Reporting and Value-Based Payment in 2016
  – Physician Quality Reporting System (PQRS)
  – Value-Based Payment Modifier (VBPM)
  – Medicare Electronic Health Record (EHR) Incentive Program

• Merit-Based Incentive Payment System (MIPS)
Learning Objectives

• Describe the requirements of the Physician Quality Reporting Program for 2016

• Describe the requirements of the Value Based Payment Modifier for 2016

• Analyze how the Merit-Based Incentive Payment System will impact the Meaningful Use Program and other quality reporting initiatives
An Introduction of How Benefits Were Realized for the Value of Health IT

• Health IT solutions that assist health care providers with performance monitoring and quality reporting increase healthcare provider satisfaction with their EHRs.

• Awareness of quality measure progress, and comparison with benchmarks assists healthcare providers to continuously improve their clinical care.

• Registries and IT solutions assist healthcare providers to securely transmit quality reporting data to CMS.

• Success in value based reimbursement (i.e., increasing quality and lowering costs) requires effective use of health IT to analyze data and engage patients at risk of poor, high-cost outcomes.

• MIPS will reward improved quality and cost efficiency through higher reimbursement: from a 4% bonus in 2019 to a 9% bonus in 2022.
Poll

• We want to know a little bit more about our audience today
• Which best describes your employer or the focus of your business?
  1. Health Information Technology Vendor
  2. Health Care Provider
  3. Both
• If you are an attorney, consultant or other advisor, please select the answer that best describes your clientele
Future of Medicare Reimbursement

• In early 2015, CMS announced plan to accelerate move of Medicare reimbursement toward value-based payment
  – Value means quality (including care coordination) and cost-effectiveness
  – Proposes to link 85% of Medicare Part A and Part B payments to quality and value by end of 2016 and 90% by end of 2018
  – Proposes to increase participation in alternative payment models, such as ACOs, to 30% by the end of 2016 and 50% by the end of 2018
Increasing Reimbursement at Risk Under Current Programs

• Certain Eligible Professionals (EPs) face penalties of **up to a 6% reduction** in reimbursement under the Medicare Physician Fee Schedule (MPFS) in 2016 if they did not report PQRS quality measures for 2014 and failed to achieve Meaningful Use (MU) in 2014
  - -2% for PQRS
  - -2% for VBPM
  - -2% for MU

• Certain EPs face **up to a 9% reduction** in MPFS reimbursement in 2017 if they do not report PQRS quality measures for 2015 and failed to achieve MU in 2015
  - -2% for PQRS
  - -4% for VBPM
  - -3% for MU
Increasing Reimbursement at Risk Under Current Programs

- Certain EPs face penalties of **up to a 10% reduction** in MPFS reimbursement in 2018 if they do not report PQRS quality measures for 2016 and failed to achieve MU in 2016
  - -2% for PQRS
  - -4% for VBPM
  - -4% for MU (if the proportion of EPs who are meaningful users is less than 75%)

- EPs may also earn an increase in MPFS reimbursement of up to 2% in 2016 and 4% in 2017 and 2018 under the VBPM
Medicare Access and CHIP Reauthorization Act (MACRA)

- Congress passed MACRA on 4/14/2015
- MACRA provides for a 5% payment bonus to eligible professionals who are qualifying alternative payment model (APM) participants
- Qualifying APM participant means an APM participant who receives 25% of payments through an eligible alternative payment entity in 2019 and 2020, and 50% in 2021 and beyond
- Bonus payment may be made on a basis other than fee-for-service depending on the eligible “alternative payment entity”
- Bonus amount based on prior year’s expenditures under MPFS
- Other eligible professionals who do not participate in a qualifying APMs are subject to Merit-Based Incentive Payment System (MIPS)
MIPS

- MIPS consolidates Medicare EP requirements of PQRS, VBPM and MU into one incentive program in 2019
- EPs rated on four weighted performance categories:
  - Quality (30%)
  - Resource Use (30%)
  - MU (25%)
  - Clinical Practice Improvement Activities (15%)
- CMS will provide a Composite Performance Score
- EP is eligible for an incentive payment or a penalty based on performance – Up to 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022 and later years
- From 2019-2024, EPs who perform exceptionally may receive an additional positive MIPS adjustment factor
### Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Updates</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Meaningful Use of Certified EHR Technology</th>
<th>PQRS, Value Modifier, EHR Incentives</th>
<th>Certain APMs</th>
<th>Qualifying APM Participant</th>
<th>Excluded from MIPS</th>
<th>5% Incentive Payment</th>
<th>MIPS Payment Adjustment (+/-)</th>
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<tbody>
<tr>
<td>2015 and earlier</td>
<td>0.5</td>
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<td>0.75 GAPMCF*</td>
<td>0.25 N-GAPMCF**</td>
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</table>

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor

Quality and Cost Measurement is Key to Value-Based Payment Methodologies

• Key to value-based payment is quality and cost measurement
• Quality and cost measurement relies on health IT to collect structured quality and cost data
• Providers’ success under the measures (i.e., high quality and efficiency) requires effective use of health IT to analyze data and engage patients at risk of poor, high-cost outcomes
• Certain measures may reward care coordination, patient engagement and/or positive patient experience even in the absence of actual quality or cost reduction gains
Measure Development

• MACRA mandates a measure development plan (MDP)
• Draft MDP released 12/31/15 and final MDP due by 5/1/16
• Draft MDP establishes requirements for the development and approval of measures for MIPS and APMs
• A key requirement is that CMS adopt comparable measures across MIPS and APMs, while considering measures used by private payers and integrated delivery systems
Figure 1: Key Dates in the Measure Development Plan

Source: CMS Quality Measure Development Plan: Supporting the Transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) (Draft) (Dec. 16, 2015).
Key PQRS Action Steps

1. Identify which clinicians are PQRS EPs
2. Decide whether to report as individual EP(s) or group
3. If group of < 100 EPs, decide whether they will conduct and report Consumer Assessment of Healthcare Providers and Systems (CAHPS) through a CMS-certified survey vendor (mandatory for ≥ 100 EP groups)
4. Review PQRS quality measures for relevance to practice
5. Determine the method for reporting the PQRS measures and report measure data
Who is a PQRS EP?

- Physicians (e.g., Doctor of Medicine, Osteopathy, Optometry or Dental Medicine)
- Practitioners (e.g., PA, APN, CNS, CRNA, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Qualified Audiologist)
- Therapists (e.g., PT, OT, SLP)
Selecting PQRS Measures

- **Individual EPs** must select 9 PQRS quality measures across 3 National Quality Strategy (NQS) domains or select a measures group.
- **Groups of ≥ 2 EPs** may either select 9 measures across 3 NQS domains; or report CAHPS patient experience survey results and select 6 measures across 2 NQS domains.
- Individuals and groups must select one cross-cutting measure.
- **Groups of ≥ 100 EPs** must report CAHPS patient experience survey.
- For each measure, report for at least 50% of Medicare FFS patients seen during the measure reporting period.
Quality Measure Example

• Diabetes: Eye Exam (Measure #117)
  - Denominator: All patients aged 18 through 75 years of age with a diagnosis of diabetes (type 1 or type 2) with a visit during the measurement period
  - Numerator: Patients who had a retinal or dilated eye exam by an eye care professional in the measurement period, or a negative retinal or dilated eye exam by an eye care professional in the year prior to the measurement period
Measures Group Option

- EPs who report individually may satisfy PQRS requirements by reporting one “measures group” via a qualified registry.
- Measures groups measure the quality of care provided to a group of patients with a particular condition such as asthma or diabetes, or patients who have undergone a particular procedure, such as cataract surgery.
- EP selects at least a 20 patient sample as a common denominator.
- Majority of the sample must be Medicare FFS patients.
Measures Group Example

- **Cataracts Measures Group** (*registry reporting only*) includes, e.g.:
  - 20/40 or better visual acuity within 90 days following cataract surgery
  - Complications within 30 days following surgery requiring additional surgical procedures
  - Improvement in visual function within 90 days following surgery, based on pre-operative and postoperative visual function survey
  - Patients satisfied with care within 90 days following surgery, based on completion of the CAHPS Surgical Care Survey
How may individual EPs report PQRS measures in 2016?

• Within Medicare Part B claims
• PQRS Qualified Registry
• Qualified Clinical Data Registry (QCDR)
• Directly from Certified EHR Technology (CEHRT)
• Data Submission Vendor (DSV) that is a CEHRT vendor
How may *group practices* report PQRS measures in 2016?

- PQRS Qualified Registry
- Qualified Clinical Data Registry (QCDR) [new for 2016]
- Web interface (for groups ≥ 25 EPs only)
- Directly from CEHRT
- DSV that is a CEHRT vendor
- CMS-certified CAHPS survey vendor
  - *Groups ≥ 100 EPs* must report CAHPS patient experience survey data through a CMS-certified survey vendor for successful PQRS reporting
  - *Group practices of 2-99 EPs* have the option to report CAHPS survey results through a CMS-certified survey vendor
<table>
<thead>
<tr>
<th>Purpose of Submission Method</th>
<th>Qualified Registry</th>
<th>QCDR</th>
<th>DSV</th>
<th>ACO/Pioneer ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission of PQRS measure data</td>
<td>Submission of PQRS and proprietary measures data and fostering quality improvement</td>
<td>Submission of eCQM data from CEHRT (eCQMs are subset of PQRS measures)</td>
<td>Submission of PQRS measure data from ACO participants</td>
<td></td>
</tr>
<tr>
<td>Registry Organization Requirements</td>
<td>Established 1 year prior to reporting year with at least 25 participants</td>
<td>Established by January 1st of reporting year with at least 50 participants</td>
<td>Must obtain certification of EHR as CEHRT (including certification for eCQMs)</td>
<td>ACOs must meet CMS program requirements and report PQRS through GPRO Web Interface</td>
</tr>
<tr>
<td>Legal Agreement with EP/Group</td>
<td>Must obtain authorization from each NPI holder and enter into BAA</td>
<td>Must obtain authorization from each NPI holder and enter into BAA</td>
<td>No CMS-required legal documents, but must enter into BAA</td>
<td>All participant TINs must enter into agreement with the ACO</td>
</tr>
<tr>
<td>Data Validation Obligations</td>
<td>Qualified Registry</td>
<td>QCDR</td>
<td>DSV</td>
<td>ACO/Pioneer ACO</td>
</tr>
<tr>
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<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>Qualified Registry Data Validation Plan Criteria</td>
<td>QCDR Data Validation Plan Criteria</td>
<td>EP’s attestation statement</td>
<td>ACO’s attestation statement</td>
</tr>
<tr>
<td>Feedback Reports</td>
<td>At least 2 per reporting year</td>
<td>At least 4 per reporting year</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GPRO Reporting</td>
<td>Permitted</td>
<td>Permitted (new for 2016)</td>
<td>Permitted</td>
<td>Required (through GPRO Web Interface)</td>
</tr>
<tr>
<td>eCQM Reporting</td>
<td>Not Permitted (Registry XML reporting)</td>
<td>Permitted</td>
<td>Permitted</td>
<td>Permitted</td>
</tr>
<tr>
<td>Measures Group Reporting</td>
<td>Permitted</td>
<td>Not Permitted</td>
<td>Not Permitted</td>
<td>Not Permitted</td>
</tr>
</tbody>
</table>
QCDR non-PQRS measure submission

• No more than 30 measures, 2 of which must be outcome measures
• Must submit non-PQRS measure specifications to CMS by March 31st of reporting period:
  – Measure description, denominator, numerator, exclusions
  – Rationale for inclusion
  – Supported evidence
  – QCDR must have a plan to risk adjust the quality measure data for which it intends to transmit to CMS

• QCDR may make measures available publically on its website, or through CMS Physician Compare
Reporting Creates Product Opportunity

- CQM reporting options create opportunities for vendors to offer additional services to customers seeking to satisfy PQRS and MU requirements
- Data collected also allows for additional data aggregation and analytics products
- QCDR reporting mechanism contemplates collection and reporting of non-PQRS and non-MU measures
PQRS Reporting and Physician Compare

Quality of Care for Patients with Diabetes

Some group practices do a better job than others at providing care that is known to get the best results for patients with diabetes. Medicare looked at a sample of patients in the group practice to help you compare how well group practices are providing the recommended care to their patients with diabetes and helping them to control their blood sugar, blood pressure, and cholesterol. Medicare used this information to give the group practice a score on each measure. The score is presented as stars and as a percent. (more information)

More stars are better.

- Controlling blood sugar levels in patients with diabetes. 65%
- Controlling blood pressure in patients with diabetes. 71%
- Prescribing aspirin to patients with diabetes and heart disease. 79%
- Patients with diabetes who do not use tobacco. 88%

Quality of Care for Patients with Heart Disease

Some group practices do a better job than others at providing care that is known to get the best results for patients with heart disease. Medicare looked at a sample of patients in the group practice to help you compare how well group practices are providing the recommended care for their patients with heart disease. Medicare used this information to give the group practice a score on each measure. The score is presented as stars and as a percent. (more information)

More stars are better.

- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions. 87%

<table>
<thead>
<tr>
<th>Year</th>
<th>Measures Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>- Diabetes Mellitus and Coronary Artery Disease measures</td>
</tr>
</tbody>
</table>
| 2015 | - Select GPRO registry and EHR measures  
      - Select individual measures collected through a registry, CEHRT, or claims  
      - CG-CAHPS summary measures for groups of ≥ 25 EPs |
| 2016 | - All individual-EP level measures collected through a QCDR, Qualified Registry, CEHRT, or claims  
      - CAHPS for PQRS for groups ≥ 2 EPs  
      - All GPRO measures reported via Web Interface, EHR, and Qualified Registry |
| 2017 | - Group practice QCDR measures (including non-PQRS QCDR measures)  
      - Item-level benchmarks for individual EP measure data |
Value Based Payment Modifier

• Performance-based adjustments to MPFS for solo practitioner EPs and groups
• MPFS payment adjustments were phased in based on group size
• In 2018, PAs, NPs, and CRNAs will also be subject to the VBPM based on 2016 data
• Increase or decrease is based upon “quality tiering” that combines a “quality measure composite score” and a “cost measure composite score” to assign group to one of three tiers
  – Performance above national mean results in MPFS rate increase
  – Average performance has a neutral effect on MPFS rates
  – Performance below national mean result in a MPFS rate decrease
VBPM Quality Composite Score

- Quality composite score based on:
  - PQRS measures reported by group/physician EP, benchmarked against national mean of measure’s performance rate; and
  - 3 outcomes measures that CMS calculates based on claims data
    - All-cause readmissions [not included for groups of 2-9 EPs, or groups of non-physician EPs]
    - Composite of acute prevention quality indicators (dehydration, urinary tract infections and bacterial pneumonia)
    - Composite of chronic prevention quality indicators (heart failure, chronic obstructive pulmonary disease and diabetes)
- For outcomes measures (and cost measures), CMS attributes beneficiary to practice that provided plurality of E&M and other primary care services to beneficiary
VBPM Quality Composite Score (Cont’d)

• Failure to report PQRS measures will lead to both downward PQRS and VBPM payment adjustments

• For purposes of VBPM, groups may report PQRS measures under GPRO option or ensure >50% of EPs report individually

• CMS determines quality tiers and calculates the VBPM at the group level, with the exception of solo practitioners (calculated individually)
VBPM Cost Composite Score

- CMS calculates “cost composite score” based on following measures:
  - *Total Per Capita Cost for all Beneficiaries*: Considers all Medicare Part A and B costs over a year
  - *Total per Capita Costs for all Beneficiaries with 4 Chronic Conditions*: Considers Part A and Part B costs for patients with COPD, Heart Failure, Diabetes and Coronary Artery Disease
  - *Medicare Spending per Beneficiary Associated with Hospitalization*: Evaluates Part A and Part B costs spanning 3 days prior to and 30 days after a hospital admission

- Measures are standardized and risk adjusted using *national* benchmarks
## 2018 VPBM Payment Adjustments

Physicians, PAs, NPs, CNSs and CRNAs in groups of physicians with ≥ 10 EPs:

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+4.0x</td>
<td>+2.0x</td>
<td>+0</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+2.0x</td>
<td>+0</td>
<td>-2.0</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0</td>
<td>-2.0</td>
<td>-4.0</td>
</tr>
</tbody>
</table>

Solo physician practitioners and groups of physicians with 2-9 EPs:

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0x</td>
<td>+1.0x</td>
<td>+0</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+1.0x</td>
<td>+0</td>
<td>+0</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0</td>
<td>+0</td>
<td>+0</td>
</tr>
</tbody>
</table>

- The ‘x’ represents the “upward payment adjustment factor”, which CMS will determine based on the aggregate amount of downward payment adjustments in CY 2016 in order to ensure budget neutrality.
- Groups and solo practitioners are eligible for an additional +1.0x if they report PQRS and their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.

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1. Revisions to Payment Policies Under the Physician Fee Schedule; Final Rule, 80 Fed Reg. 70886, 71290 (Nov. 16, 2015)
EHR Incentive Program in 2016

• Achievement of MU in 2016 required to avoid 2018 MPFS payment adjustment (and to avoid in 2017 for first-time meaningful EHR user)

• MACRA sunsets EHR incentives/adjustments 12/31/18, but achievement of MU will continue to be relevant for MIPS

• Achievement of MU will be one component of performance measurement under MIPS
2016 eCQM Selection and Reporting

- CEHRT must be certified to at least 9 of 64 available eCQMs
- CMS also releases update to electronic specifications to eCQMs, but does not require re-certification of CEHRT to specifications
- As with PQRS, EP must select 9 eCQMs across 3 NQS domains
- If reporting as a group practice, and group reports CAHPS for PQRS survey modules, group may report 6 eCQMs across 2 of the NQS domains
- eCQM data must be captured and calculated using CEHRT; manual abstraction of data is not permitted
- eCQM reporting required for entire reporting period to achieve MU in 2016; 90-day period only for 2015
2016 eCQM Reporting Options

• If an EP individually reports eCQMs for PQRS and wants to report eCQMs once for both PQRS and EHR Incentive Program, EP may report eCQMs:
  – Directly from CEHRT
  – Through DSV that is a CEHRT vendor
  – Via Qualified Clinical Data Registry

• If EP intends to report eCQMs for MU and PQRS separately, the EP may continue to report eCQMs through the EHR Registration and Attestation System until 2018
2016 eCQM Reporting Options (cont’d)

• If EPs are reporting eCQMs for PQRS as a group and the group wants to report eCQMs once for both PQRS and the EHR Incentive Program, the group may report the eCQMs:
  – Directly from CEHRT
  – Through a DSV that is CEHRT
  – Through GPRO Web Interface
  – Through Shared Savings Program ACO or Pioneer ACO

• EPs in a group may report eCQMs through the EHR Registration and Attestation System until 2018 (but would also need to separately report eCQMs for PQRS)
CMS-ONC RFI on eCQMs and CEHRT

- Published in the Federal Register on 12/31/2015
- Sought feedback on 3 issues concerning the certification of CEHRT to eCQM specifications:
  1. Frequency of certification of CEHRT for eCQM specifications
  2. Minimum number of eCQMs that CEHRT must certify
  3. Increasing robustness of eCQM testing and certification
- Feedback will impact future CMS and ONC regulations and guidance
Objective 10 requires “active engagement” with a public health agency (PHA) to submit electronic public health data.

Objective 10 measures include:
- M1: Active engagement with PHA to submit immunization data
- M2: Active engagement with PHA to submit syndromic surveillance data
- M3: Active engagement to submit data to a specialized registry

EP may attest to Measure 3 more than once.

“Active engagement” means: registration; testing and validation; or electronic submission of production data.

ONC has not established standards or certification criteria for electronic submission of data to specialized registries, but may adopt such standards in future rulemaking prior to Stage 3.
MIPS: Clinical Practice Improvement Activities

- MACRA provides that Clinical Practice Improvement Activities (CPIA) will account for 15% of performance measurement under MIPS.
- MACRA defines 6 subcategories of CPIA, but leaves open CPIA submission process and how CMS will measure successful CPIA.
- CMS will use CPIA submissions to evaluate whether the activity can be developed into quality measures under the CPIA subcategories.
- CMS regulations will define specific activities as CPIA for MIPS.
- For example, CMS stated in the draft MDP that providers that use patient-reported tools (e.g., PHQ-9 for depression) for improvement purposes could submit data to CMS from the use of these tools and data could inform patient-reported outcome measure development by CMS.
Clinical Practice Improvement (cont’d)

• “Clinical Practice Improvement” includes six subcategories:
  – Expanded practice access
  – Population management
  – Care coordination
  – Beneficiary engagement
  – Patient safety and practice assessment
  – Participation in alternative payment models

• MIPS EP is not required to perform activities in all six subcategories to receive highest score for CPI
Clinical Practice Improvement (cont’d)

• “Beneficiary engagement” includes establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms

• “Care coordination” includes timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth

• “Population management” includes monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry
A Summary of How Benefits Were Realized for the Value of Health IT

- Health IT solutions that assist health care providers with performance monitoring and quality reporting increase healthcare provider satisfaction with their EHRs.

- Awareness of quality measure progress, and comparison with benchmarks assists healthcare providers to improve their clinical care throughout the year.

- Qualified registries, QCDRs, and Data Submission Vendors assist healthcare providers to securely transmit quality reporting data to CMS.

- Success in value based reimbursement (i.e., increasing quality and lowering costs) requires effective use of health IT to analyze data and engage patients at risk of poor, high-cost outcomes.

- MIPS will reward quality improvement and better cost efficiency through higher reimbursement: from a 4% bonus in 2019 to a 9% bonus in 2022.
Questions

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