Meaningful Use: The Next Chapter

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Today's presenter:

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In collaboration with:

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

NEW ENGLAND QUALITY INNOVATION NETWORK
Administered By Healthcentric Advisors in Partnership with Qualidigm

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Agenda

- Expanded Role of Health IT Drives Change
  - Payment Reform
  - Quality Reporting
  - Practice Transformation
- New CMS Initiatives
  - CMS Meaningful Use Rules 2015-2017
  - Meaningful Use Stage 3 Rules
  - Medicare Access and CHIP Reauthorization Act (MACRA)
- Riding the Waves of Change
- Massachusetts eHealth Institute (MeHI)
- Questions and Answers

Expanded Role of Health IT

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Expanded Role of Health IT Drives Change

- Payment Reform
- Quality Reporting
- Practice Transformation

Improve Care Delivery Outcomes

New CMS Initiatives

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CMS Meaningful Use Rules: 2015-2017

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CMS Final Rule – Changes to Participation Timeline

2015	Attest to modified criteria for 2015-2017 (Modified Stage 2) with accommodations for Stage 1 providers
2016	Attest to 2015-2017 criteria (Modified Stage 2)*
2017	Attest to either 2015-2017 criteria (Modified Stage 2) **or** full version of Stage 3 using 2015 Edition CEHRT
2018	Attest to full version of Stage 3 using 2015 Edition CEHRT

**some alternate exclusions remain in 2016 for Stage 1 providers*

CMS Final Rule – Changes to EHR Reporting Periods

- In 2015, all providers attest using an EHR reporting period of any continuous 90-day period within the calendar year
- In 2016:
  - first-time MU participants will attest using any continuous 90-day period within the calendar year
  - returning participants will attest using a **full calendar year** (January 1, 2016 through December 31, 2016)
- In 2017:
  - first-time MU participants and anyone choosing to demonstrate Stage 3 will attest using any continuous 90-day period within the calendar year
  - returning Stage 2 participants will attest using the **full calendar year** (January 1, 2017 through December 31, 2017)
- In 2018, all providers will attest to Stage 3 using the **full calendar year** (January 1, 2018 through December 31, 2018)

CMS Final Rule – List of Objectives

- Meaningful Use Objectives – Modified Stage 2
  1. Protect Patient Health Information – Security Risk Analysis
  2. Clinical Decision Support (CDS)
  3. Computerized Provider Order Entry (CPOE)
  4. Electronic Prescribing (eRx)
  5. Health Information Exchange (HIE) – *previously known as "Summary of Care"*
  6. Patient Specific Education
  7. Medication Reconciliation
  8. Patient Electronic Access (Patient Portal)
  9. Secure Electronic Messaging (Eligible Professionals only)
  10. Public Health and Clinical Data Registry Reporting
      a. Immunization Registry Reporting
      b. Syndromic Surveillance Reporting
      c. Specialized Registry Reporting
      d. Reportable Lab Results Reporting (Eligible Hospitals only)

[Note: No change in General Requirements or Clinical Quality Measure reporting]

CMS Meaningful Use Rules: Stage 3

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Stage 3 Meaningful Use - Objectives

1. Protect Electronic Health Information
2. Electronic Prescribing (eRx)
3. Clinical Decision Support
4. Computerized Provider Order Entry (CPOE)
5. Patient Electronic Access to Health Information
6. Coordination of Care through Patient Engagement
7. Health Information Exchange
8. Public Health Reporting

Stage 3 Meaningful Use – Key Elements

- Coordination of Care through Patient Engagement
  - 10% of patients use portal or API
  - 25% of patients must receive message from EP
  - 5% of patients enter their own data or may come from other agencies

Stage 3 Meaningful Use – Key Elements

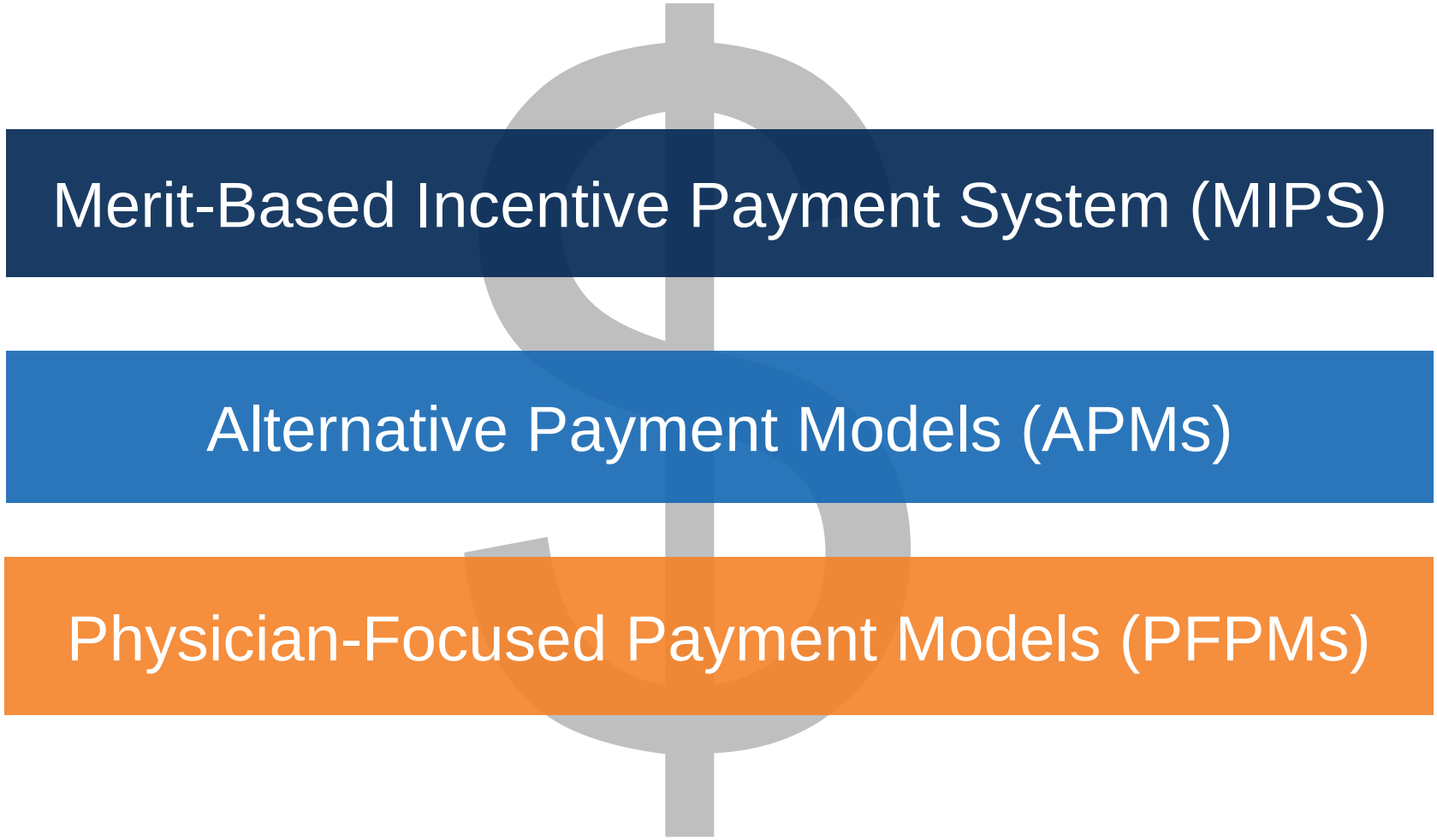
- Health Information Exchange
  - 50% of outgoing referrals/transitions sent electronically
  - 40% of incoming referrals/transitions and new patients come with summaries of care
  - 80% of incoming referrals/transitions and new patients have medications, allergies, and problem lists reconciled

Stage 3 Meaningful Use – Key Elements

- Public Health Reporting
  - Must report 3 measures
  - Registries
    - Immunization
    - Syndromic Surveillance
    - Electronic Case Reporting
    - Other Public Health Registries
    - Clinical Data Registries

Medicare Access and CHIP Reauthorization Act (MACRA)

Emerging Payment Methodologies



Medicare Access and CHIP Reauthorization Act (MACRA)

- MACRA replaces the Sustainable Growth Rate (SGR) with a combination of:
  - payment adjustments and incentives for providers who participate in pay-for-performance programs and Alternative Payment Models (APMs)
- MACRA is designed to improve upon the SGR methodology
  - more predictable than SGR, which depended on previous year's expenditures
  - increases number of physicians participating in APMs to encourage quality and efficiency
  - physicians in high-quality, efficient practices may benefit financially
  - designed to promote quality of care over quantity/volume
- CMS is currently developing proposals to implement key elements of MACRA

MACRA Reimbursement Rates

- For 2015 - 2019, annual increase (fee schedule update) of 0.5%
- Starting in 2019, the base reimbursement rate holds steady
  - Physicians can supplement their reimbursement through participation in the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models, such as Accountable Care Organizations (ACOs)
  - APM incentive payment (5% lump sum) will be available from 2019 through 2024
  - MIPS payment adjustments based on composite performance score increase from +/- 4% in 2019 to +/- 9% in 2022 and beyond
- Starting in 2026, an annual increase (fee schedule update) of 0.25% resumes
  - physicians who participate in an Alternative Payment Model (APM) are eligible for a higher annual increase of 0.75%

Merit-Based Incentive Payment System (MIPS)

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Merit-Based Incentive Payment System (MIPS)

- Merit-Based Incentive Payment System (MIPS) consolidates three existing programs
  - Physician Quality Reporting System (PQRS)
  - Value-based Modifier (VM)
  - EHR Incentive Payment Program (Meaningful Use)
- For the 2015 and 2016 performance years (and the respective 2017 and 2018 payment years), the PQRS, Value-based Modifier and MU programs will continue as separate and distinct programs

MIPS Eligible Professionals

First two years

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Nurse Anesthetists

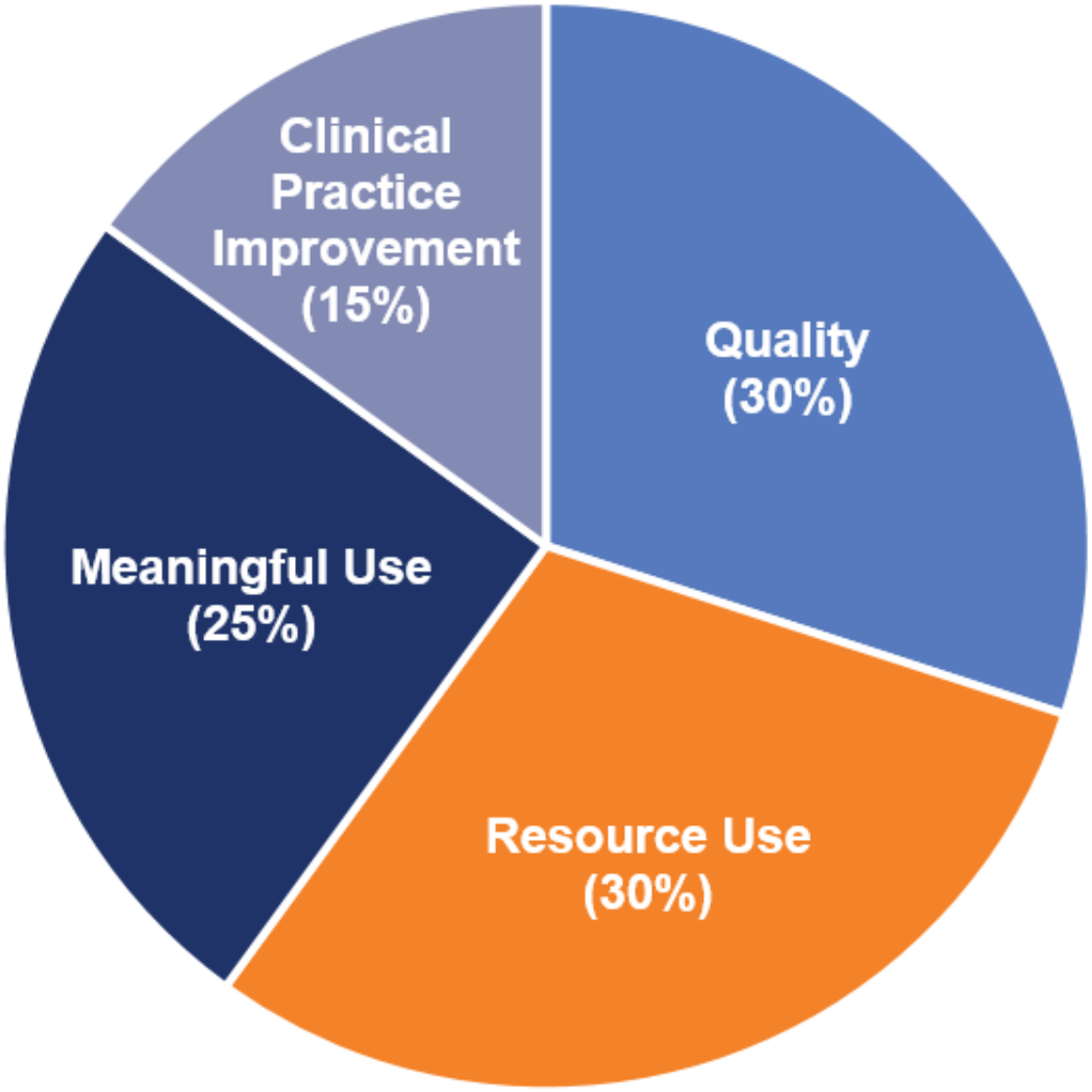
Third year and beyond

- All of the above, plus:
- Physical Therapists
- Occupational Therapists
- Speech-language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dietitians

Transition to MIPS

2016-2018	2019
Remains the Same	Replaced by MIPS
• Physician Quality Reporting System (PQRS) • Value-based Modifier (VM) • EHR Incentive Payment Program (Meaningful Use)	• MIPS payment adjustments will range from **+/- 4%** in 2019 to **+/- 9%** in 2022 and beyond

MIPS Composite Performance Score



MIPS Performance Category: Quality

30% of an EP's MIPS composite performance score is determined by performance in the Quality category

- Measures will include:
  - Quality measures currently used in existing (PQRS and VM);
  - Clinical Quality Measures (CQMs) currently used for Meaningful Use;
  - Measures currently used by Qualified Clinical Data Registries (QCDR) may also be included; and
  - Additional measures to be solicited by CMS from professional organizations and others in the health care community.
- National Quality Strategy (NQS) Domains:
  - Clinical Processes/Effectiveness
  - Patient Safety
  - Care Coordination
  - Patient and Family Engagement
  - Population/Public Health
  - Efficient Use of Healthcare Resources

MIPS Performance Category: Resource Use (cost)

30% of an EP's MIPS composite performance score is determined by performance in the Resource Use category

Resource Use measures:

- Are enhanced through public input;
- Directly engage professionals;
- Allow professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist);
- Allow professionals to report the type of treatment (e.g., chronic condition, acute episode);
- Are designed to not penalize providers for serving sicker or more costly patients

MIPS Performance Category: Clinical Practice Improvement

15% of an EP's MIPS composite performance score is determined by performance in the Clinical Practice Improvement category

- Clinical Practice Improvement includes the following categories:
  - Expanded practice access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety
  - Practice assessment
- EPs who work in a certified Patient-Centered Medical Home (PCMH) or "comparable specialty practice" will receive the maximum score of 15 in this category
- EPs who participate in an APM will receive a minimum score of 7.5 in this category

MIPS Performance Category: Meaningful Use of CEHRT

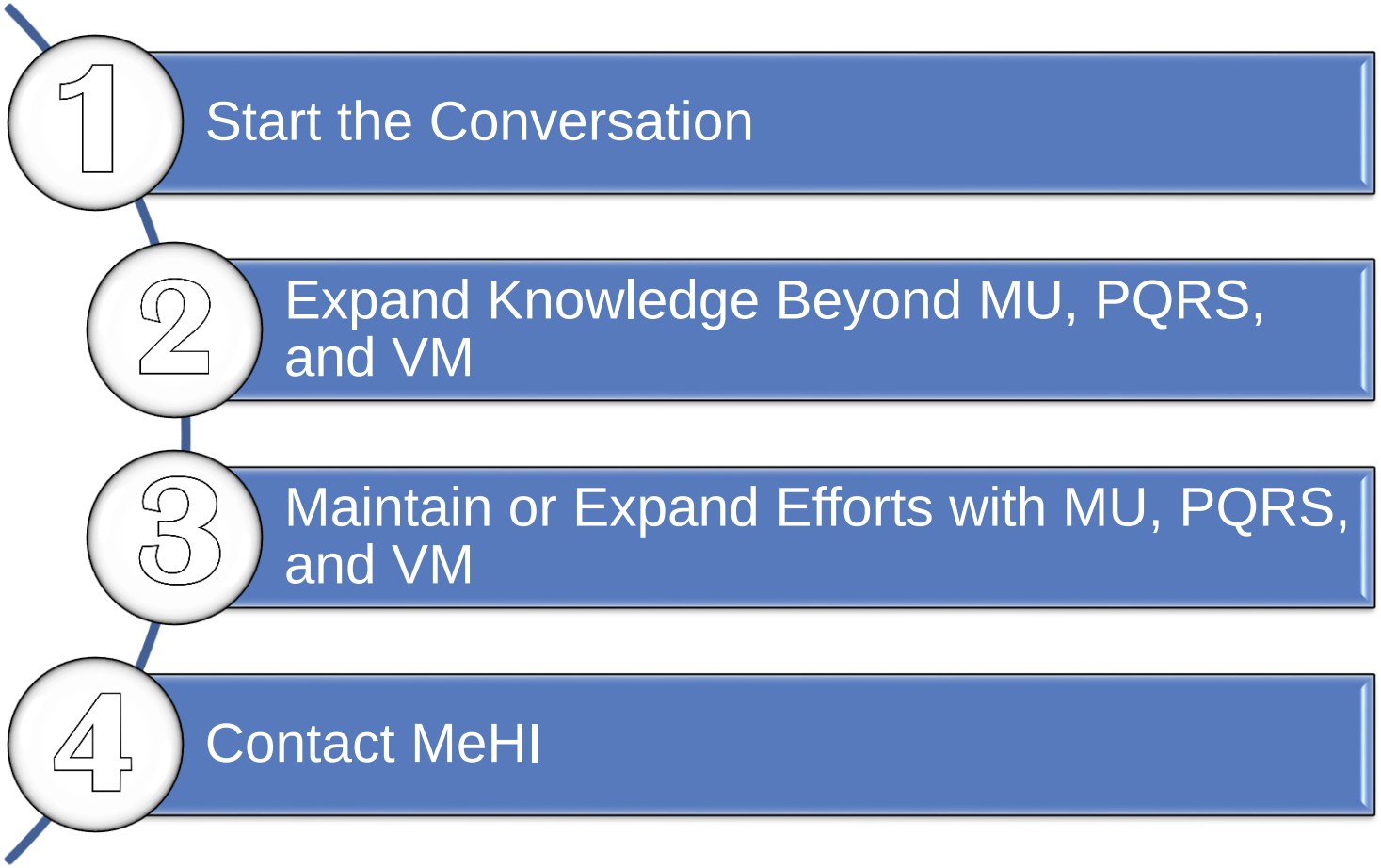
25% of an EP's MIPS composite performance score is determined by performance in the Meaningful Use of CEHRT category

- Measures and activities are the same as current MU requirements
- CMS may reduce the weight for this performance category
  - Not below 15%
  - Any year in which the proportion of EPs who are Meaningful Users is estimated to be 75% or greater
  - Result: An increase in the percentage weights for the other categories

Timeline: Implementation of MIPS

- Existing programs such as PQRS, Value Modifier and Meaningful Use have a 2-year delay from performance year to payment year
  - 2016 performance dictates 2018 payment adjustments, and so on
- Anticipated that 2017 will be the first MIPS performance year
  - 2017 performance would dictate 2019 payment adjustments
- CMS will further define the performance years and other details of MIPS in a Final Rule
  - Anticipated publication date – end of 2016
  - Stage 3 MU, optional in 2017 and mandatory in 2018, will be measured solely under the MIPS program (no standalone Medicare MU penalties)
  - Final Rule will also address how group performance and individual performance will affect MIPS scores

Four Steps to Prepare for MIPS



Alternative Payment Models (APMs)

Alternative Payment Models (APMs)

- An eligible APM entity:
  - requires participants to use certified EHR technology
  - provides payment for covered professional services based on quality measures “comparable to” MIPS quality measures, AND
  - either requires participants to bear financial risk for monetary losses under the APM that are in excess of a nominal amount, OR is a medical home model
- Example: Medicare Shared Savings Program ACO
- CMS predicts that only a small minority of providers will qualify for the APM incentive payment in the early years

Alternative Payment Models (APMs)

Incentive payments for participation in eligible APMs under two options:

Medicare Thresholds: Certain % of Medicare payments attributable to services furnished through an eligible APM	**All-Payer Thresholds:** Certain % of All-Payer **and** Medicare payments attributable to services furnished through an eligible APM
If a provider exceeds Medicare payment thresholds, they receive a 5% Bonus	If a provider exceeds All-Payer and Medicare payment thresholds, they receive a 5% Bonus
If a provider exceeds MIPS payment threshold, but is below Medicare payment thresholds, participation in MIPS is optional (Partially Qualifying APM Participant)	If a provider exceeds MIPS threshold, but is below All-Payer and Medicare payment thresholds, participation in MIPS is optional (Partially Qualifying APM Participant)

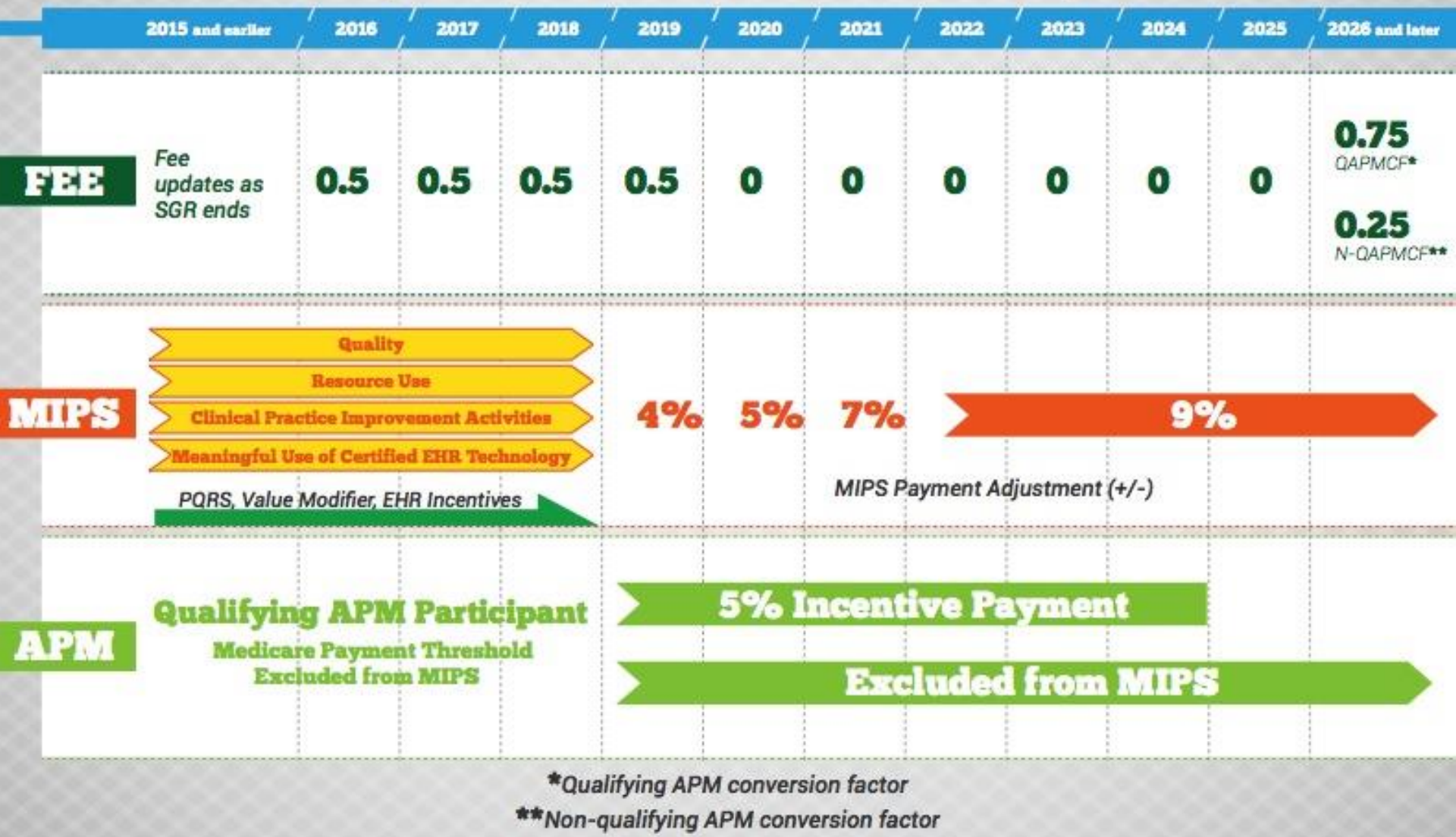
Physician-Focused Payment Models (PFPMs)

Physician-Focused Payment Models (PFPMs)

New Proposed Payment and Service Delivery Model Process

- Details of process and criteria will be forthcoming in anticipated 2016 Final Rule

Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Riding the Waves of Change

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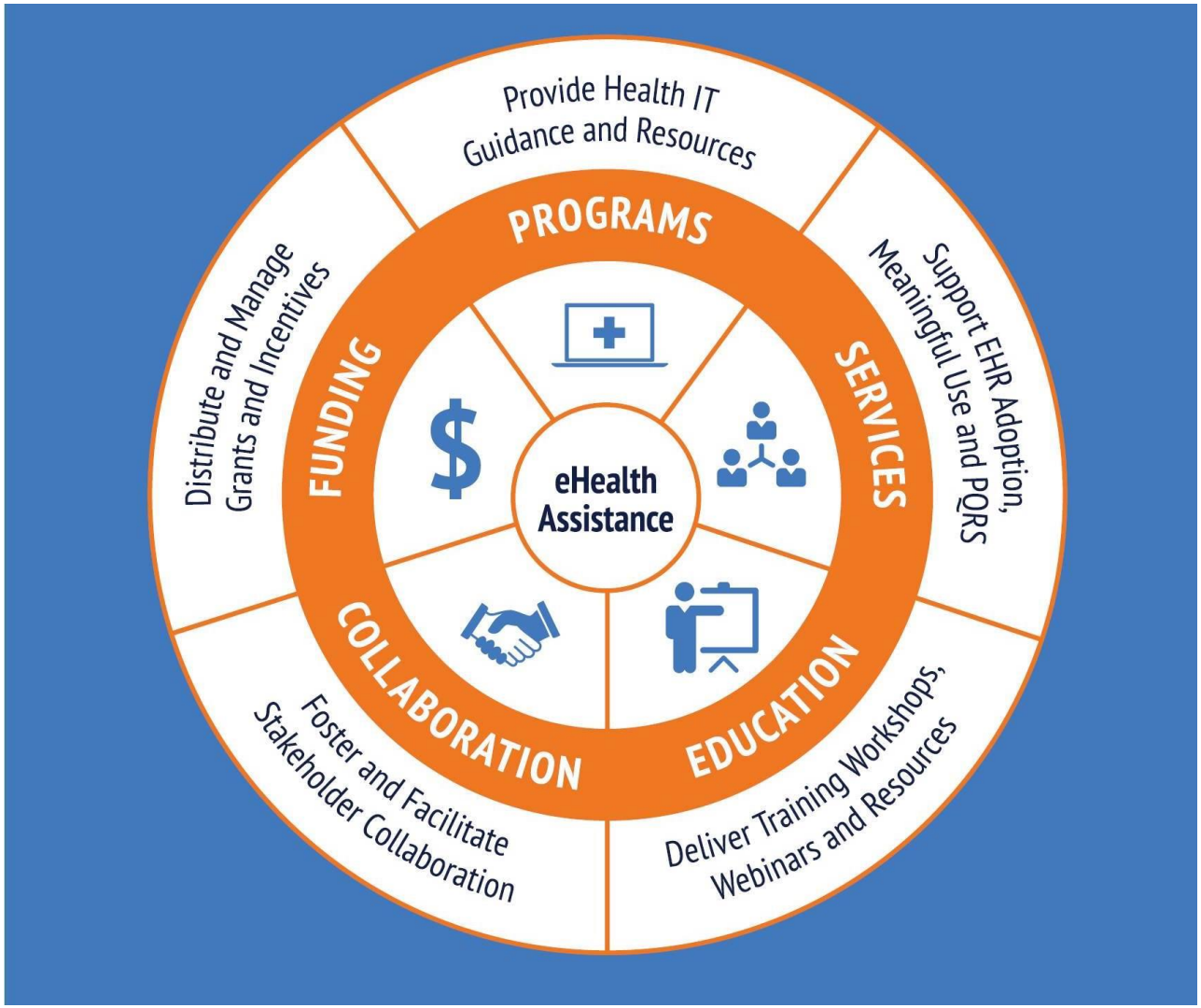

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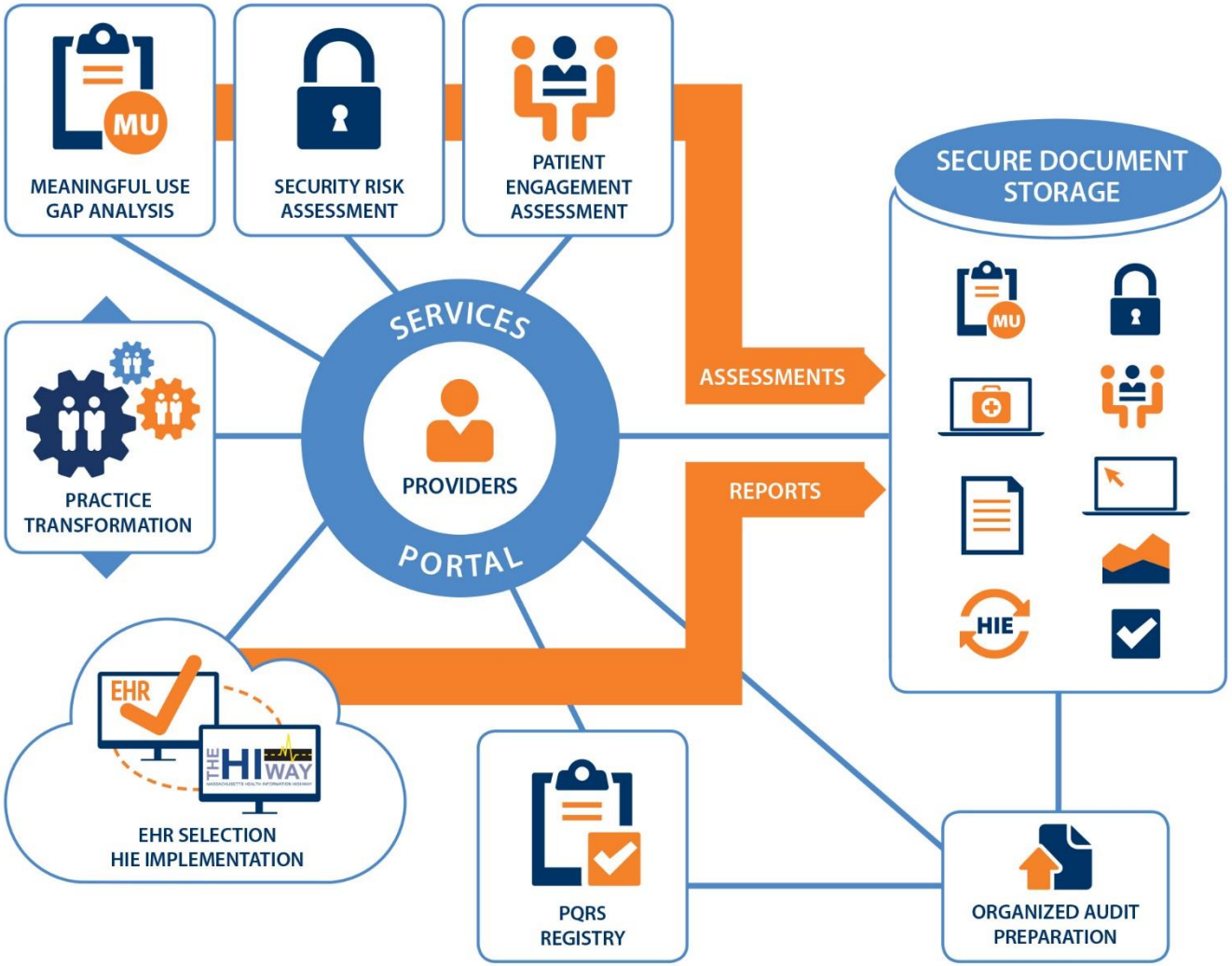
MeHI's eHealth Services



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Questions

Questions?

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The New England Quality Innovation Network – Quality Improvement Organization (New England QIN-QIO)

brought to you by:

- **Healthcentric Advisors**
  - Focus areas: MA, ME, RI
- **Qualidigm**
  - Focus areas: CT, NH, VT

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