



HIMSS[®] 16

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HEALTH THROUGH IT



CMS Listening Session: EHR Incentive Programs in 2018 & Beyond

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Conflict of Interest

Dr. Kate Goodrich and Robert Anthony have no real or apparent conflicts of interest to report.

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Listening Session Goals

1

Provide an Overview of Stage 3

2

Discuss What's Next for the EHR Incentive Programs

3

Stakeholder Feedback

Where We Are Now?

- On October 6, 2015, CMS released a final rule for the Medicare and Medicaid EHR Incentive Programs in 2015 through 2017 and Stage 3 in 2018 and beyond.
- The final rule included a 60-day comment period to generate feedback on certain Stage 3 provisions, and the future of the program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- CMS received **more than 500 comments** on the Stage 3 portion of the rule.

What are the goals of Stage 3?

- Provide a flexible, clear framework to simplify the meaningful use program and reduce provider burden.
- Ensure future sustainability of Medicare and Medicaid EHR Incentive Programs.
- Advance the use of health IT to promote health information exchange and improved outcomes for patients.

Achieving EHR Incentive Program Goals

- Synchronize on single stage and single reporting period.
- Reduce burden by removing objectives that are:
 - Redundant, paper-based versions of now electronic functions
 - Duplicative of other more advanced measures using same certified EHR technology function
 - Topped out and have reached high performance
- Focus on eight advanced-use objectives.

Stage 3 Objectives

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- 1 **Protect Patient 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 and Clinical Data Registry Reporting**

Stage 3 EHR Reporting Period and Participation Timeline

2017

Attest to either 2015-2017 criteria or full version of Stage 3

All returning participants use an **EHR reporting period of a full calendar year** (January 1 – December 31, 2017). First-time participants and providers attesting to Stage 3 may use a 90-day EHR reporting period.

2018

Attest to full version of Stage 3

All returning participants use an **EHR reporting period of a full calendar year** (January 1 – December 31, 2018). First-time Medicaid participants may use a 90-day EHR reporting period.

Future of the Medicare EPs & EHR Incentive Programs under MACRA

- The EHR Incentive Programs will move beyond the “staged” approach to Meaningful Use by 2018, which will help providers prepare for MIPS and collectively move forward to a system based on the quality of care delivered.
- Physicians will be measured on meaningful use of EHR technology for the purpose of determining their Medicare payments.
- Under MACRA, all programs will be guided by the following critical principles:
 - Rewarding providers for **patient outcomes**
 - Allowing **flexibility to customize** health IT to individual practice needs
 - **Leveling the technology playing field** to promote innovation by unlocking electronic health information through open Application Program Interfaces (APIs)
 - **Prioritizing interoperability** by implementing federally recognized, national interoperability standards **and focusing on real-world uses of technology**

Medicaid & Hospitals Not Affected



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



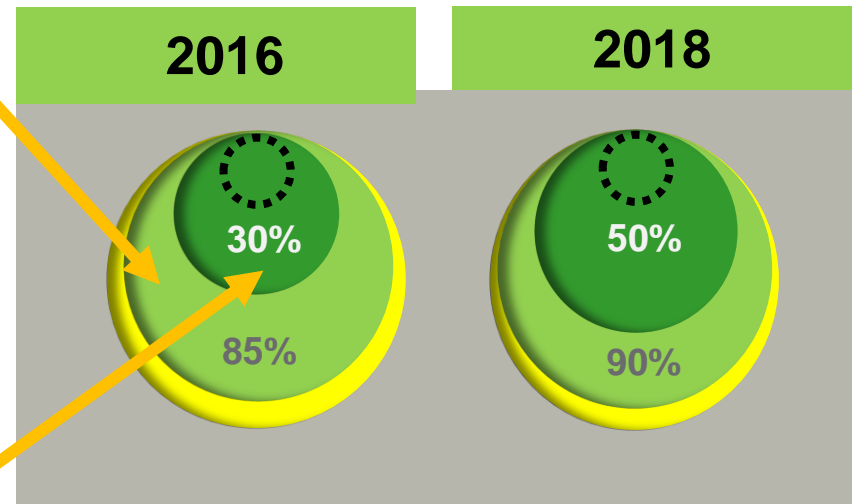
Invite **private sector payers** to match or exceed HHS goals

MACRA moves us closer to meeting these goals...

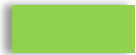
The new Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

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:



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 under MACRA

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)

MACRA Goals

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)

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



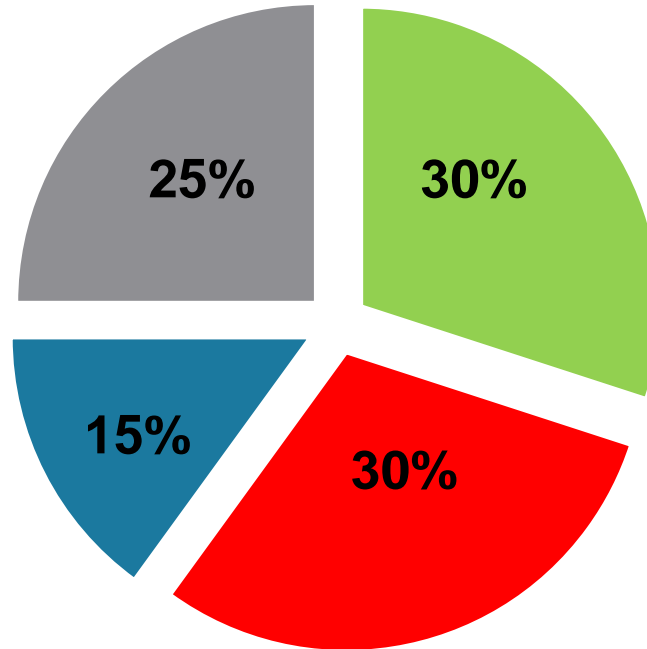
Meaningful use of certified EHR technology



MIPS Performance Score

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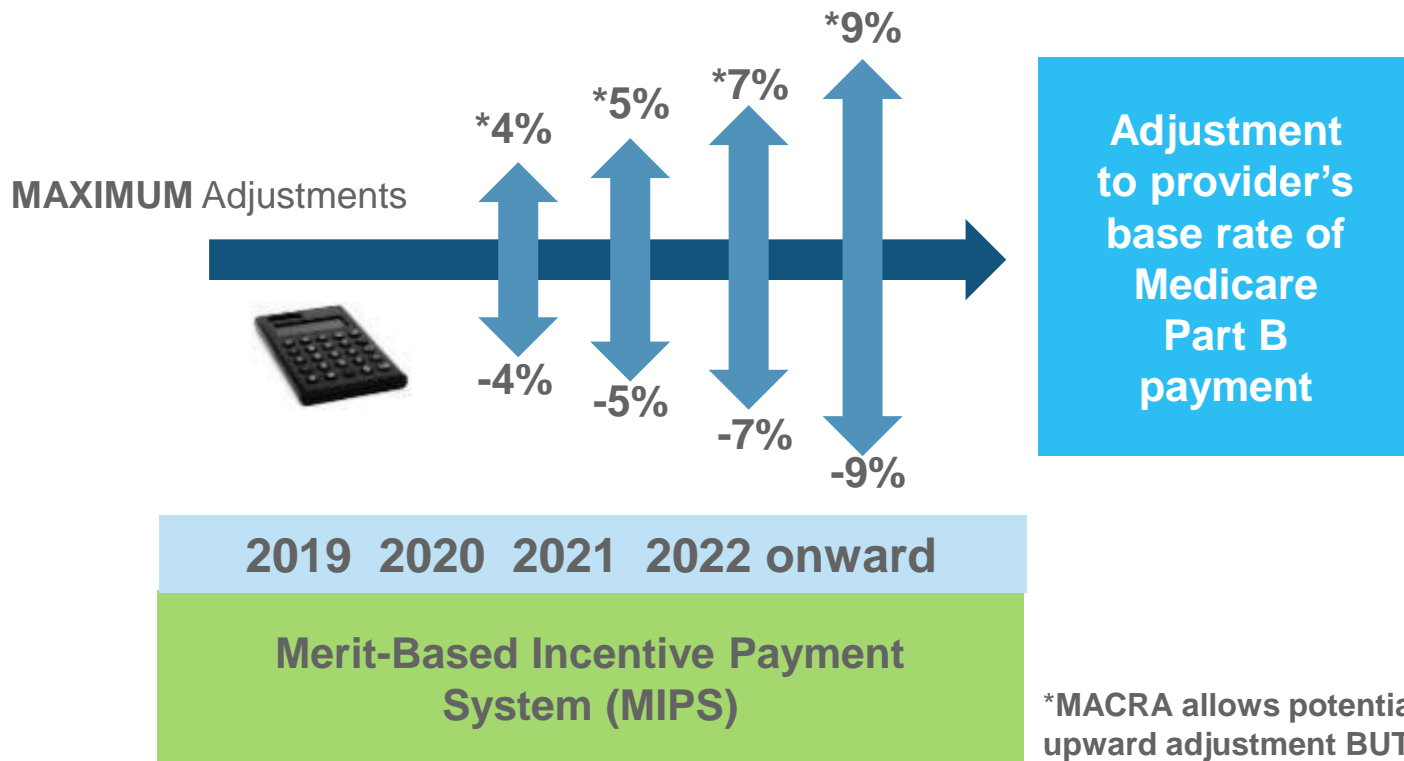
Weighted Performance Categories



- Quality Measures
- Resource Use
- Clinical Practice Improvement Activities
- Meaningful Use of EHRs

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.



*MACRA allows potential 3x upward adjustment BUT unlikely

Discussion: Ground Rules



Topics for Discussion

Scoring Questions for Meaningful Use of Certified EHR Technology under MIPS:

- Should the performance score for this category be based solely on full achievement of Meaningful Use?
- What changes should CMS make to the current structure for the Meaningful Use performance category?
- Should CMS use a tiered methodology for determining levels of achievement in this category?
- What alternate methodologies should CMS consider for this performance category?
- How should hardship exemptions be treated?

Topics for Discussion

- General questions or comments about the Stage 3 criteria?
- Does the structure of the Stage 3 program and its requirements offer enough flexibility?
- Does it address interoperability challenges?
- Any feedback on how CMS can best incorporate the EHR Incentive Programs into MIPS?
- What steps can CMS take to help providers and the health care community to prepare for Stage 3 and MIPS?

Join CMS Sessions at HIMSS16

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

Visit CMS Office Hours at Booth 10309

Office Hours Topic	Time
Tuesday, March 1	
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

Questions and Comments

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Thank You!