CMS Listening Session:
EHR Incentive Programs in 2018 & Beyond

Kate Goodrich, MD, MHS, Director, Center for Clinical Standards and Quality
Robert Anthony, Deputy Director, Quality Measurement & Value-Based Incentives Group
Center for Clinical Standards and Quality

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest

Dr. Kate Goodrich and Robert Anthony have no real or apparent conflicts of interest to report.
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We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
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

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

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

**2017**

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.

Attest to full version of Stage 3

**2018**

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**

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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% Medicare FFS payments linked to quality and value (Categories 2-4)
  - 85% Medicare payments linked to quality and value via APMs (Categories 3-4)
  - 0% Medicare Payments to those in the most highly advanced APMs under MACRA

- **2018**
  - 50% Medicare FFS payments linked to quality and value (Categories 2-4)
  - 90% Medicare payments linked to quality and value via APMs (Categories 3-4)
  - 50% 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 Composite Performance Score
MIPS Performance Score

Weighted Performance Categories

- Quality Measures: 25%
- Resource Use: 15%
- Clinical Practice Improvement Activities: 30%
- Meaningful Use of EHRs: 30%
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.

MAXIMUM Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustment to provider’s base rate of Medicare Part B payment</th>
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<tbody>
<tr>
<td>2019</td>
<td>-4%</td>
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<tr>
<td>2020</td>
<td>-5%</td>
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<tr>
<td>2021</td>
<td>-7%</td>
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<tr>
<td>2022 onward</td>
<td>-9%</td>
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*9%

*5%

*7%

*4%

*9%

Merit-Based Incentive Payment System (MIPS)

*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

## Tuesday, March 1

<table>
<thead>
<tr>
<th>Title</th>
<th>Session</th>
<th>Time &amp; Location</th>
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<tbody>
<tr>
<td>CMS EHR Incentive Programs in 2015 through 2017 Overview</td>
<td>26</td>
<td>10:00 a.m. – 11:00 a.m. Palazzo B</td>
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<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. Palazzo B</td>
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<tr>
<td>A Special Session with ONC and CMS (Presentation by Dr. Karen DeSalvo and Andy Slavitt)</td>
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<td>5:30 p.m. – 6:30 p.m. Rock of Ages Theatre</td>
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## Wednesday, March 2

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<tr>
<th>Title</th>
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<tbody>
<tr>
<td>CMS Listening Session: Merit-Based Incentive Payment System (MIPS)</td>
<td>101</td>
<td>8:30 a.m. – 9:30 a.m. Palazzo B</td>
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<tr>
<td>CMS Electronic Clinical Quality Measurement (eCQM) Development and Reporting</td>
<td>131</td>
<td>11:30 a.m. – 12:30 p.m. Palazzo B</td>
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## Thursday, March 3

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<th>Title</th>
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<tr>
<td>Interoperability Showcase: eCQM Submissions</td>
<td>N/A</td>
<td>10:00 a.m. – 11:00 a.m. Booth #11954</td>
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<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. Palazzo B</td>
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<td>Quality Measurement Development and Reporting</td>
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Questions and Comments
EHRInquiries@cms.hhs.gov
Thank You!