CMS Update

Address to the Association of Medical Directors of Information Systems

June 20, 2018

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Objectives for today

- CMS Strategic Goals
- Key Initiatives Update
  - Opioid Initiative
  - Innovation Center
  - Quality Payment Program Update
- Reducing Administrative Burden
  - Patients over Paperwork & Meaningful Measures Initiatives
  - Example: the IPPS proposed rule
- Questions

CMS Strategic Goals

1. Empower patients and clinicians to make decisions about their health care.

2. Usher in a new era of state flexibility and local leadership.

3. Support innovative approaches to improve quality, accessibility, and affordability.

4. Improve the CMS customer experience.

Medicare Trustees Report

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

- Medicare costs (including both HI and SMI expenditures) will grow from approximately 3.7% of GDP in 2017 to 5.9% of GDP by 2042, and then increase gradually to about 6.2% of GDP by 2092.

- The SMI Trust Fund, which covers Medicare Part B and D, had $88 billion in assets at the end of 2017.

- Medicare's Hospital Insurance (HI) Trust Fund assets increased by $2.8 billion to $202.0 billion at the end of 2017.

- The Trustees project that the HI Trust Fund will be depleted in 2026, three years earlier than indicated in last year's Medicare report.

Advancing Value over Volume

CMS NEWS

FOR IMMEDIATE RELEASE
April 24, 2018

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

CMS Proposes Changes to Empower Patients and Reduce Administrative Burden

Changes in Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System would advance price transparency and interoperability

Today, the Centers for Medicare & Medicaid Services (CMS) proposed changes to empower patients through better access to hospital price information, improve patients' access to their electronic health records, and make it easier for providers to spend time with their patients. The proposed rule issued today proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

"Patients must be at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families." – May 7, 2018 Remarks by Administrator Seema Verma at the American Hospital Association Annual Membership Meeting

MyHealthEData Initiative

https://bluebutton.cms.gov/

Giving patients control of their health records

- It is NOT acceptable to limit patient records or to prevent them and their doctors from seeing their complete history
- Launch "Digital Seniors" initiative: recognize the increasing role of technology in seniors' lives; update Medicare resources accordingly

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

CMS Roadmap

TO ADDRESS THE **OPIOID EPIDEMIC**

Opioids killed more than 42,000 in 2016, or 116 people a day.[2]

40% of all opioid overdose deaths involve a prescription opioid.[1]

PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

TREATMENT

Expand access to treatment for opioid use disorder

DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse

PRESCRIPTION OPIOID MISUSE

When used correctly, prescription opioids are **helpful** for treating pain.

The CDC outlined **guidelines** for safe prescribing of opioids.

An estimated **11.5 million** people misused prescription opioids[2]—putting them at risk for dependence and addiction.

3 out of 4 people who used heroin misused prescription opioids first.[3]

OPIOID USE DISORDER

Over **two million** people suffer from opioid use disorder.

Treatment **options** exist, including medication-assisted treatment (MAT).

Only 20% of people with opioid use disorder receive treatment.[3]

Learn more about prescription opioid misuse

Learn more about opioid use disorder and treatment

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PREVENTION

Significant progress has been made in identifying overprescribing patterns

TREATMENT

Medicare, Medicaid, and private health plans provide some coverage for pain and opioid use disorder treatments

DATA

Data provides insight into doctor, pharmacy, and patient use of prescription opioids and effectiveness of treatment

CMS CAN BUILD ON THESE EFFORTS TO FURTHER:

1. **Identify** and stop overprescribing of opioids
2. **Enhance** diagnosis of OUD to get people the support they need earlier
3. **Promote** effective, non-opioid pain treatments

1. **Ensure** access to treatment across CMS programs and geography
2. **Give** patients choices for a broader range of treatments
3. **Support** innovation through new models and best practices

1. **Understand** opioid use patterns across populations
2. **Promote** sharing of actionable data across continuum of care
3. **Monitor** trends to assess impact of prevention and treatment solutions

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

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Medicare Part D Opioid Prescribing Mapping Tool

The Medicare Part D opioid prescribing mapping tool is an interactive tool that shows geographic comparisons, at the state, county, and ZIP code levels, of de-identified Medicare Part D opioid prescription claims – prescriptions written and then submitted to be filled – within the United States. The mapping tool presents Medicare Part D opioid prescribing rates for 2016 as well as the change in opioid prescribing rates from 2013 to 2016.

The mapping tool allows the user to see both the number and percentage of opioid claims at the local level in order to better understand how this critical issue impacts communities nationwide. By openly sharing data in a secure, broad, and interactive way, CMS and the U.S. Department of Health and Human Services (HHS) believe that this level of transparency will inform community awareness among providers and local public health officials.

The data reflect Medicare Part D prescription drug claims prescribed by health care providers. Approximately 70% of Medicare beneficiaries have Medicare prescription drug coverage either from a Part D plan or a Medicare Advantage Plan offering Medicare prescription drug coverage. In 2016, Medicare Part D spending was $146 billion; U.S. retail prescription drug spending was about $329 billion. The mapping tool does not contain beneficiary information nor does the information presented in this tool indicate the quality or appropriateness of care provided by individual physicians or in a given geographic region.

Note: the map will automatically adjust between state, county, and zip code levels as users zoom in or out. Zooming is available by clicking on the zoom buttons in the top left corner of the map, or by using the mouse wheel or keyboard "+" or "-" keys. Users can navigate the map by dragging with the mouse or by using the keyboard arrow keys. To ensure full functionality of the tool, using a browser other than Internet Explorer may be required.

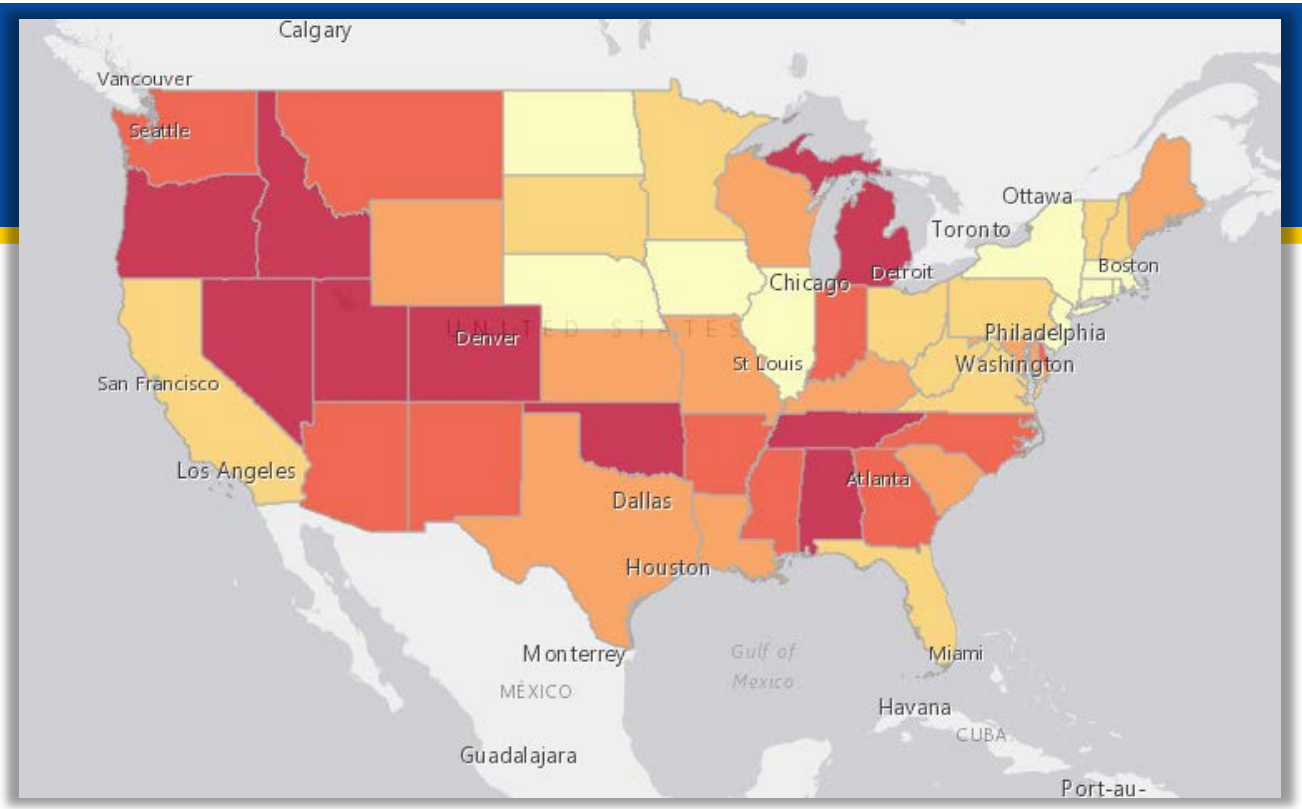
Opioid Mapping Tool

View Prescriber Level Opioid Rates

Download Opioid Map Data

Part D Prescriber Look-up Tool

https://go.cms.gov/opioidheatmap



- Download Opioid Map Data
- View Prescriber-level Opioid rates
- Part D Prescriber Look-up tool

https://go.cms.gov/opioidheatmap

Highlighting Innovation

MEDICAID DEMONSTRATION PROJECT

CMS approved an 1115 Medicaid demonstration project for Virginia and worked with the state to strengthen the delivery system for substance use disorder, including opioid use disorder.

Virginia's Medicaid demonstration project has significantly improved access to treatment by increasing reimbursement, which led to increased provider capacity and a 49% increase in number of members accessing opioid treatment services and a 39% decrease in opioid-related emergency department visits in the first 5 months.[5]

COLLABORATIVE LEARNING

The Transforming Clinician Practice Initiative (TCPI) run by CMS is a collaborative learning initiative that facilitates information sharing and practice reform on a large scale, with over 90% of clinicians operating in small, rural, or underserved areas participating. One TCPI member—the Integrated Pain Care program at Community Care of West Virginia—achieved promising results, including:

1. Zero opioid-related deaths among the 2,628 patients over the past 2 years
2. A reduction in opioid prescriptions by 86% in 4 years.[6]

HUB AND SPOKE MAT

CMS approved and provided technical assistance to Vermont on their Hub and Spoke MAT program to add the Health Home optional Medicaid state plan benefit to promote coordinated care for chronic conditions, which has led to dramatic reductions in opioid use, overdoses and emergency department visits related to opioid use.

ADVANCED ANALYTICS

CMS' Quality Improvement Organization provided advanced data analytic support and clinical expertise to a network of 10 hospitals and partners across Colorado to change pain management practices and improve care. Over a 6-month timeframe, CMS data showed that these hospitals achieved a 36% reduction in the use of opioids—about 35,000 fewer administrations of opioids in the emergency department—and an increase in alternative medications by 31%.

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https://www.hhs.gov/opioids/about-the-epidemic/index.html

The CMS Innovation Center **was created by the Affordable Care Act to develop, test, and implement new payment and delivery models**

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Innovation Center portfolio aligns with broader CMS goals

Focus Areas	CMS Innovation Center Portfolio*
Pay Providers	**Test and expand alternative payment models** ▪ **Accountable Care** – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Comprehensive ESRD Care Initiative – Next Generation ACO ▪ **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project – Medicare Diabetes Prevention Program ▪ **Bundled payment models** – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ **Initiatives Focused on the Medicaid** – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ **Dual Eligible (Medicare-Medicaid Enrollees)** – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Medicare-Medicaid ACO Model ▪ **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design Model – Part D Enhanced Medication Therapy Management
Deliver Care	**Support providers and states to improve the delivery of care** ▪ **Learning and Diffusion** – Partnership for Patients – Transforming Clinical Practice ▪ **Health Care Innovation Awards** ▪ **Accountable Health Communities** ▪ **State Innovation Models Initiative** – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health Model – Vermont All-Payer ACO Model ▪ **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** ▪ **Information to providers in CMMI models** ▪ **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas

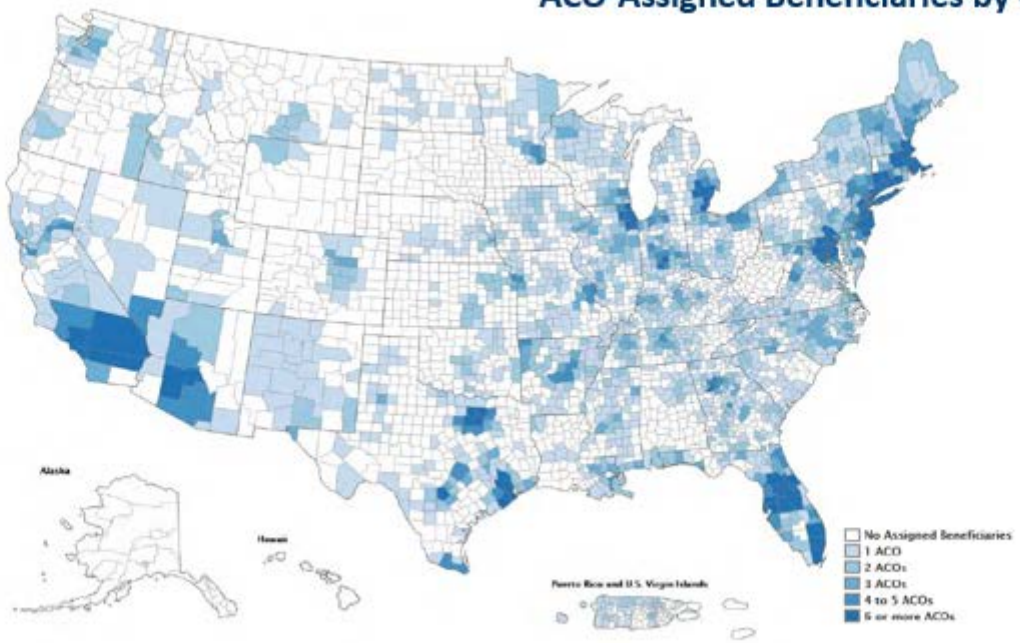
Medicare Shared Savings Program

Better Care for **Individuals.**

Better Health for **Populations.**

Lowering Growth in **Expenditures.**

ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

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Report in Brief
August 2017
OEI-02-15-00450

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Review

Medicare spending is expected to grow to $1.4 trillion by 2027. To control this increase and promote quality and healthy populations, the Centers for Medicare & Medicaid Services (CMS) has implemented and is considering a number of alternative payment models that reward providers for the quality and value of services. The goal is to incentivize providers to keep patients healthy and thus lower costs.

The Medicare Shared Savings Program is one of the largest alternative payment models. As part of this program, health care providers form Accountable Care Organizations (ACOs) to coordinate care to reduce costs and improve quality of care. Information about the extent to which ACOs are able to reduce Medicare spending and improve quality is critical to inform future developments as ACOs and

Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality

What OIG Found

Over the first 3 years of the program, 428 participating Shared Savings Program ACOs served 9.7 million beneficiaries. During that time, most of these ACOs reduced Medicare spending compared to their benchmarks, achieving a net spending reduction of nearly $1 billion. One-third of ACOs reduced spending enough to receive a portion of the savings. ACOs participating in the program longer were more likely to reduce spending and by greater amounts than other ACOs. This suggests that more established ACOs are learning how to achieve greater cost savings over time.

Key Takeaway

Most Shared Savings Program ACOs were able to reduce Medicare spending and improve quality of care in the first 3 years of the program. A small subset of these ACOs showed substantial reductions in Medicare spending for key services.

As alternative payment models further take shape, these high-performing ACOs are worth a close look to understand the strategies they are employing.

At the same time, ACOs generally improved the quality of care they provided, based on CMS's data on quality measures. In the first 3 years, ACOs improved their performance on most (82 percent) of the individual quality measures. These 33 measures track various aspects of care provided to beneficiaries, such as the percentage of beneficiaries screened for depression. ACOs also outperformed fee-for-service providers on most (81 percent) of the quality measures.

Full report can be found at
http://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

New Direction - CMS Innovation Center Request for Information (RFI)

The RFI seeks broad input related to a new direction for the CMS Innovation Center that will promote **patient-centered care** and **test market-driven reforms** that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, and improve outcomes.

The administration plans to launch models in several focus areas:

- Expanded Opportunities for Participation in Advanced APMs
- Consumer-Directed Care & Market-Based Innovation Models
- Physician Specialty Models
  - Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models
- Prescription Drug Models
- Medicare Advantage (MA) Innovation Models
- State-Based and Local Innovation, including Medicaid-focused Models
- Mental and Behavioral Health Models
- Program Integrity

Guiding Principles

- Choice and competition in the marketplace
- Provider choice and incentives
- Patient-centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing

https://innovation.cms.gov/initiatives/direction/

Additional APM and Innovation Resources

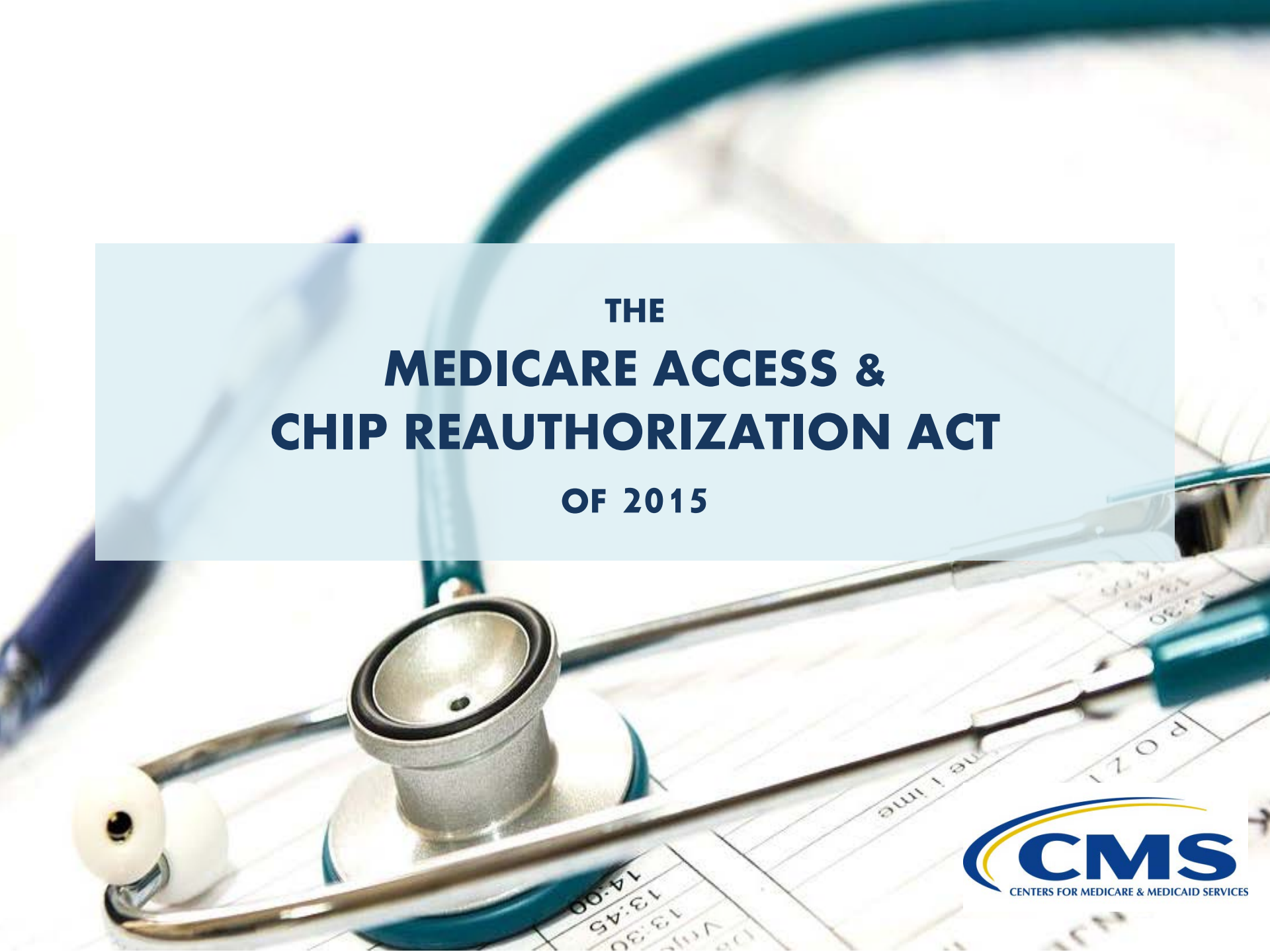
https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Alternative-Payment-Model-APM-Design-Toolkit.pdf

Opportunities for Innovations that are not Alternative Payment Models

What if my idea is for care redesign?.....

What if my idea is a new quality measure?.....

What if my idea is a software or technology solution?.....



THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015

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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.

The Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

CMS

qpp.cms.gov

MIPS Year 2 (2018)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

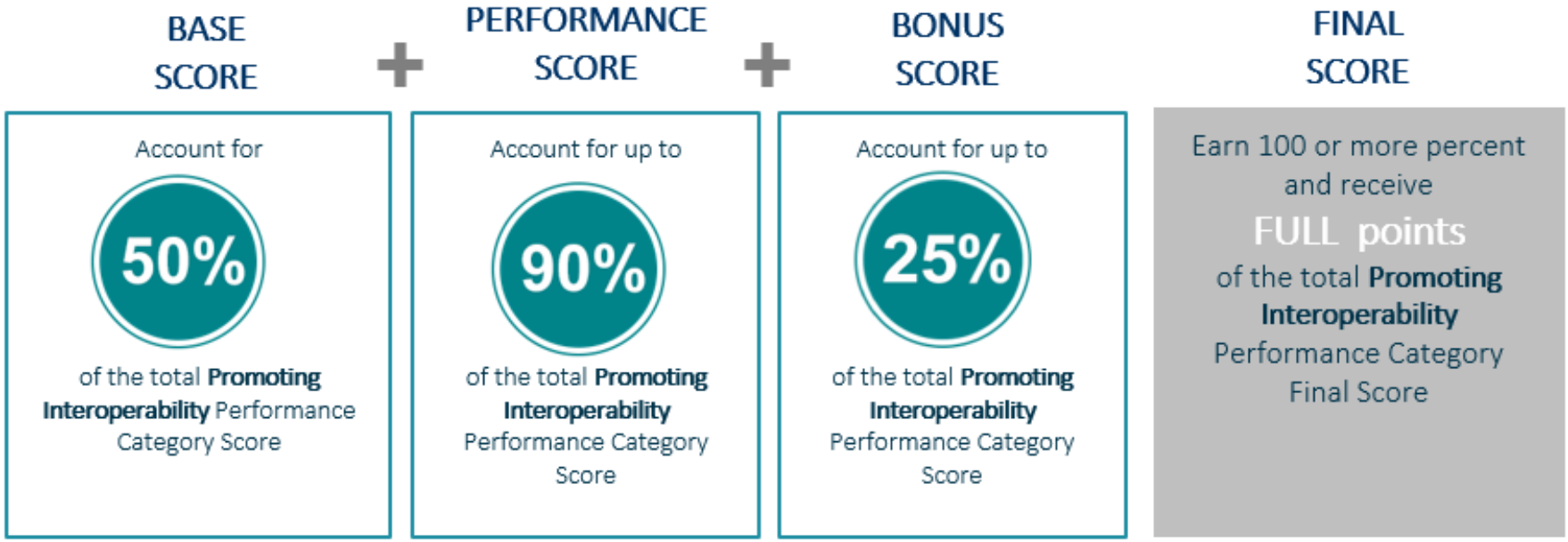
MIPS Year 2 (2018)

Changing Advancing Care Information to Promoting Interoperability

- We have established a new name for the MIPS Advancing Care Information performance category – the **Promoting Interoperability** performance category.
- This new name better reflects CMS' new focus on promoting interoperability and the sharing of health care data between health care providers and patients.
- The name change does not affect or alter any of the established requirements for the 2018 performance year.

Promoting Interoperability

Performance Category Total Score



Remember: The Promoting Interoperability Performance Category Final Score is **worth 25%** of your total MIPS Final Score.

You may earn a maximum score of up to 165% within the performance category, but we will cap your total score at 100%. This was designed to give you maximum flexibility to focus on measures that are relevant to you and your practice.

Promoting Interoperability

Scoring Example

Scenario:

- Individual MIPS eligible clinician.
- Currently using 2014 Edition CEHRT.
- Opts to report on the Promoting Interoperability Transition Measures and Objectives set.
- Will not claim the e-Prescribing or HIE exclusions.
- Will not take additional steps to fulfill the Bonus score.

Promoting Interoperability

Scoring Example

Base Score:

Measure	Result
Security Risk Analysis	Yes
E-Prescribing	30/750
Provide Patient Access	250/750
Health Information Exchange	650/750

Fulfilled Base Score = 50%

Promoting Interoperability

Scoring Example

Performance Score:

Measure	Num/Denom	Perf Rate	Percentage Score
Provide Patient Access	250/750	33%	8% (worth 20%)
Health Information Exchange	650/750	87%	18% (worth 20%)
View, Download, or Transmit	475/750	63%	7%
Secure Messaging	100/750	13%	2%
Medication Reconciliation	250/750	33%	4%
Total Performance			**39%**

Promoting Interoperability

Scoring Example

Total Performance Category Score:

Base Score	50%
Performance Score	39%
Bonus Score	0%
Total Score	89%
Calculate the contribution to MIPS Final Score	89% x .25 = 22.25 points
Final Performance Category Score	**22.25 points***

*Earn 100% or more and receive the full 25 points for the Promoting Interoperability Performance Category

Promoting Interoperability

Annual Call for Measures and Activities for MIPS

- Allows providers and measure stewards from stakeholder organizations to identify and submit EHR measures for the Promoting Interoperability performance category.

- CMS is requesting:
  - Outcome-based measures;
  - Patient safety measures; and
  - Measures that could be applicable to NPs, PAs, CRNAs, and CNSs

Promoting Interoperability

Measures Submission

- The measure for consideration submission form includes the following criteria:
  - Measure description;
  - Measure type (if applicable), examples include outcome measure, process measure, patient safety measure, etc.;
  - Measure numerator and numerator description;
  - Measure denominator and denominator description;
  - Any applicable measure exclusions; and
  - CEHRT functions utilized.

Promoting Interoperability

Measure Submission

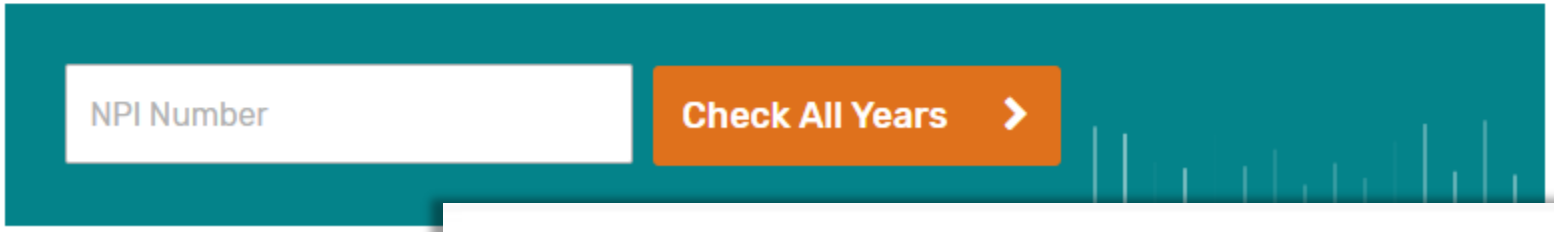
- Measures for consideration should be submitted to: CMSCallforACIMeasures@gdit.com.
- Submission deadline is **Friday, June 29, 2018.**
- For more information, see the Call for Measures fact sheet found here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Call-for-Measures-and-Activities.zip.

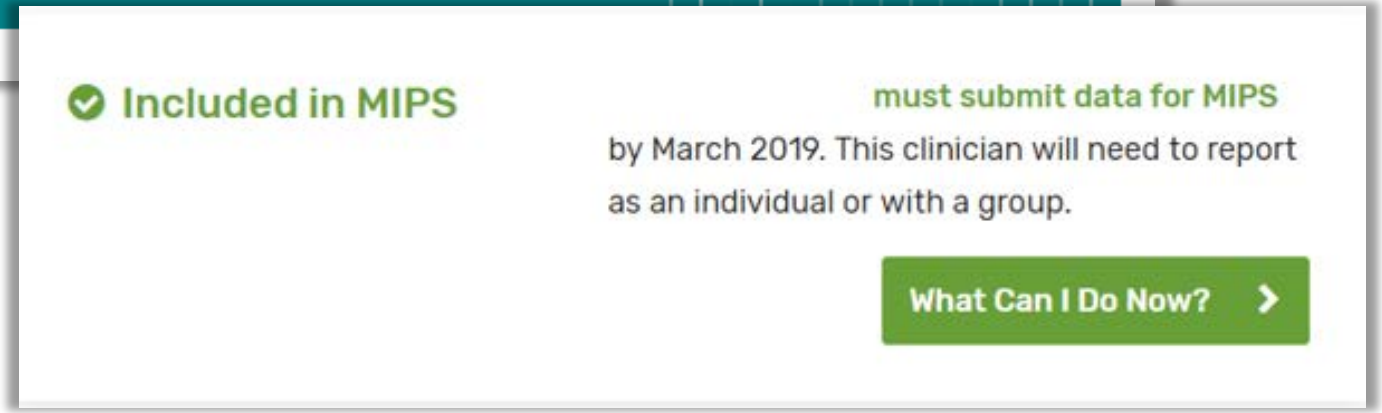
More information and webinars posted at https://qpp.cms.gov

QPP Participation Status

Enter your 10-digit National Provider Identifier (NPI) number to view your MIPS participation status by performance year (PY).

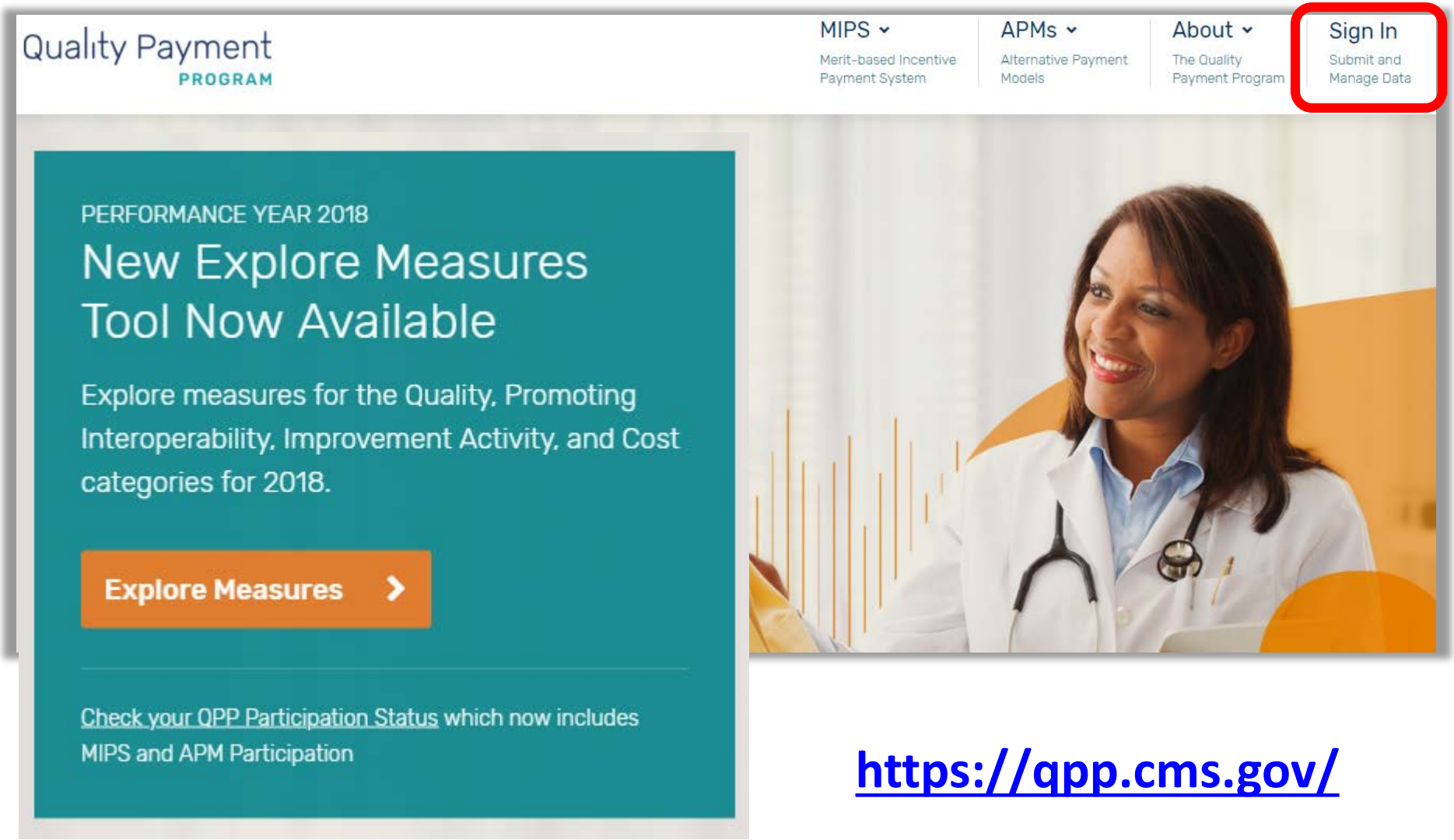
QPP Participation Status includes APM Participation as well as MIPS Participation.





https://qpp.cms.gov/participation-lookup

Log in using your EIDM credentials
to check your group's 2018 eligibility for MIPS



https://qpp.cms.gov/

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact [redacted] for extra assistance.

Locate the PTNs and SANs in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or for assistance getting connected, contact [redacted]

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

PATIENTS OVER PAPERWORK

https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

https://go.cms.gov/cpi

ReducingProviderBurden@cms.hhs.gov

PATIENTS
OVER PAPERWORK

Documentation Requirements Simplification

Administrator Verma's Charge:

- Simplify our requirements
- Make them easier to understand
- Get rid of requirements we no longer need
- Seek input from stakeholders
- Challenge the way we have always done things

We Need Your Input:

ReducingProviderBurden@cms.hhs.gov

PATIENTS OVER PAPERWORK

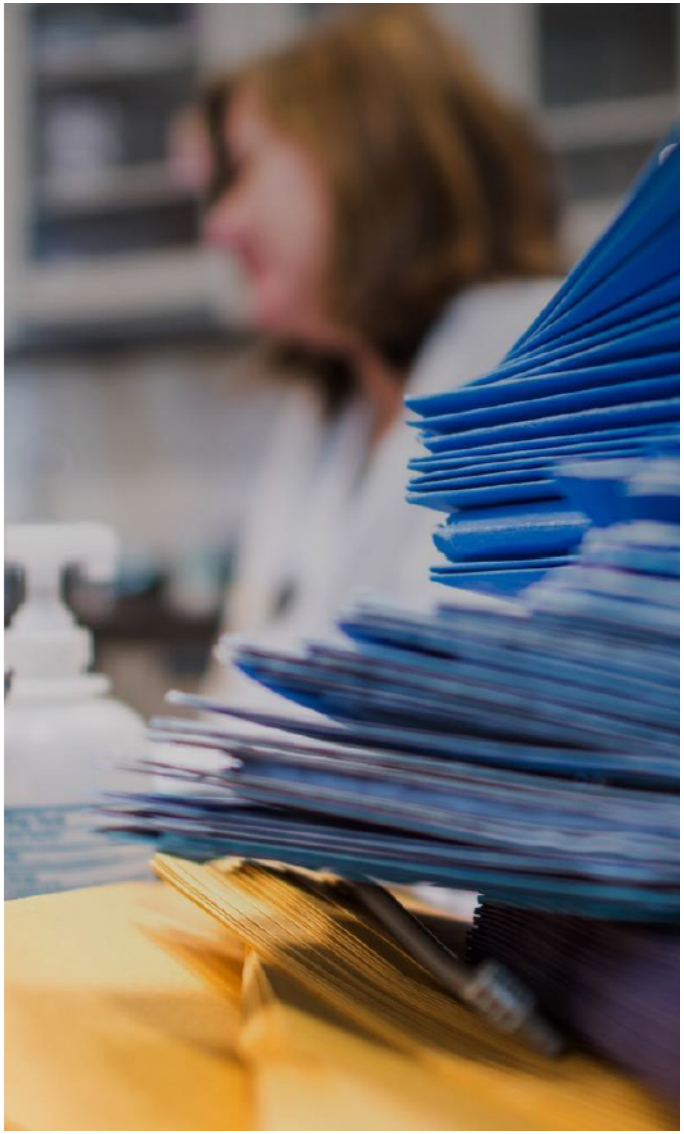
CCSQ Sub-Regulatory EHR and Quality Payment Program (QPP) Accomplishments

1. Clarified guidance that clinicians may use **scribes** for EHR documentation so long as the clinician validates and signs off on the documentation.
2. Developed an **API** for data submission under QPP that can be used for reporting to MIPS for clinicians using registries or QCDRs
3. Developed a very user friendly **website for QPP** for obtaining information and submitting data.

PATIENTS OVER PAPERWORK

Documentation Requirements Simplification Accomplishments

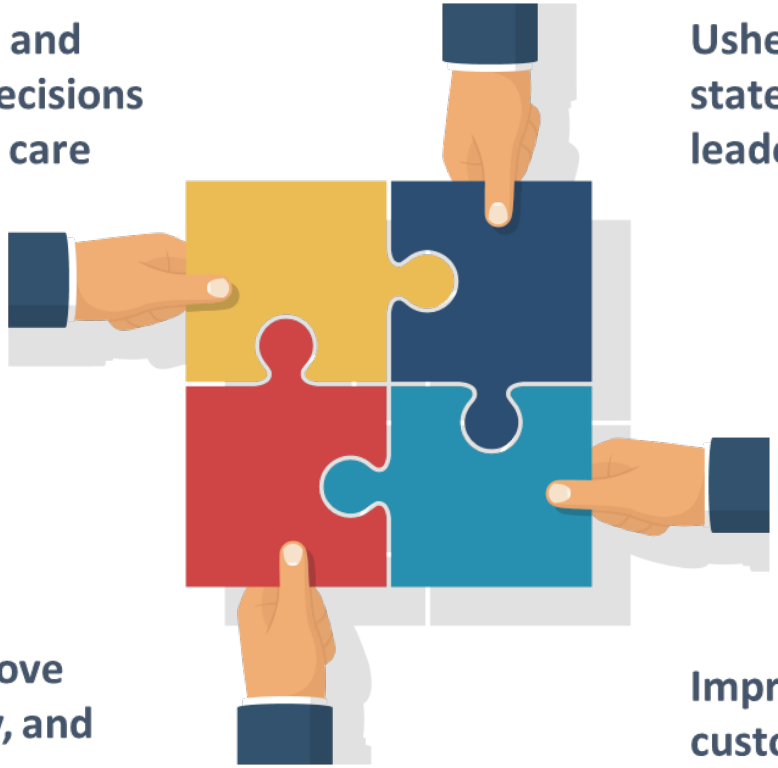
- E/M Med Student Documentation
  - Now allow teaching physicians to verify in the medical record student documentation of E/M services, rather than re-documenting the student's notes
- Signature Requirements
  - Claims won't be denied if support staff forget to sign part of the record
- When MACs should check for Proof of Delivery
  - Will not be requested for every item
- Therapeutic Shoe Inserts
  - Now allow payment for inserts made with digital technology, without an actual impression of the foot
- IRF Medical Review Policy
  - Claims won't be denied just because a certain number of therapy hours weren't met



Meaningful Measures:
A New Approach to Meaningful Outcomes

Empower patients and doctors to make decisions about their health care

Usher in a new era of state flexibility and local leadership



Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

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Meaningful Measures Framework

Meaningful Measure Areas Achieve:

- ✓ *High quality healthcare*
- ✓ *Meaningful outcomes for patients*

Criteria meaningful for patients and actionable for providers

Draws on measure work by:

- Health Care Payment Learning and Action Network
- National Quality Forum – *High Impact Outcomes*
- National Academies of Medicine – *IOM Vital Signs Core Metrics*

Includes perspectives from experts and external stakeholders:

- Core Quality Measures Collaborative
- Agency for Healthcare Research and Quality
- Many other external stakeholders

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Meaningful Measures

Give us your feedback!
MeaningfulMeasuresQA@cms.hhs.gov

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Make Care Affordable
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

EXAMPLE: CMS Quality Measure Development Plan and the Core Quality Measures Collaborative

- **CMS Quality Measure Development Plan**
  - Highlight known measurement gaps and develop strategy to address these
  - Promote harmonization and alignment across programs, care settings, and payers
  - Assist in prioritizing development and refinement of measures

2018 Measure Development Plan Annual Report: https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development.html

- **Core Measures Sets**
- Initially released in 2016, new PEDIATRIC measure set released 2017
  - ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics
  - Pediatrics

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

EXAMPLE: IPPS Proposed Rule

- Issued on April 24, 2018
- Deadline for submitting comments on the proposal and the RFI is **June 25, 2018**.

- Proposing to remove certain measures from the Hospital IQR Program
  - Consistent with CMS' commitment to using a smaller set of more meaningful measures
  - Focusing on measures that provide opportunities to reduce both paperwork and reporting burden on providers and patient-centered outcome measures, rather than process measures.

- To accomplish these goals, CMS is proposing to adopt a new measure removal factor and to update the Hospital IQR Program's measure set as follows:
  - Adopt one additional factor to consider when evaluating measures for removal from the Hospital IQR Program measure set: "The cost associated with a measure outweighs the benefit of its continued use in the program".
  - Remove 18 previously adopted measures that are "topped out", no longer relevant, or where the burden of data collection outweighs the measure's ability to contribute to improved quality of care.
  - De-duplicate 21 measures to simplify and streamline measures across programs. These measures will remain in one of the other 4 hospital quality programs

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

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