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Meet the Presenter…

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute

On the topic:
Physician Quality Reporting and Meaningful Use Updates
Physician Quality Reporting and Meaningful Use

Presented by:
Maxine I Collins, MBA, CPA, CMC, CMOM, CMIS
Consultant/Instructor Practice Management Institute
Director of Compliance, Audit and Education,
CoreMD Partners, LLC.

CMS Authorized Programs & Activities

- Target surveys
  - Quality Assurance Performance Improvement
- Coverage of services
- Physician Feedback report
- Quality Resource Utilization Report
- Hospital Readmissions
- Reduction Program
- Health Care Associated Conditions Program
- ESRD QIP
  - Physician value modifier
  - Plans for Skilled Nursing Facility and Home Health Agencies, Ambulatory Surgical Centers
- QIOs
  - ESRD Networks
  - Hospitals, Home Health Agencies, Hospices, ESRD Facilities

- Payment
  - Value-Based Purchasing
- Value & Public Reporting
- Quality & Public Reporting
- CMS
- Accountable Care Organizations
  - Community Based Transitions Care Program
  - Dual eligible coordination
  - Care model demonstrations & projects
  - 1115 Waivers
- Program Integrity
  - EHR Incentive Program
  - Medicare Part B Incentive Program
- Fraud & Abuse Enforcement
- Coverage
  - National & Local decisions
  - Mechanisms to support innovation (CER, parallel review, other)
- Hospital Inpatient: Quality Hospital Outpatient
  - Inpatient psychiatric hospitals
  - Cancer hospitals
  - Nursing homes
  - Home Health Agencies
  - Long-term Care Acute Hospitals
  - Inpatient rehabilitation facilities
  - Hospices
MEDICARE 2016 INCENTIVE PROGRAMS

2016 REPORTING AS IT CURRENTLY STANDS

Introduction to Quality Reporting
Improving the quality of care through real-time feedback for Medicare & Medicaid Services (CMS). For over a decade, the U.S. Department of Health and Human Services (HHS) and CMS have focused heavily on increasing quality in health care for all Americans through accountability and public disclosure. CMS supports health care providers in achieving better health outcomes for their patients through care improvement and public disclosure.

Quality Reporting is an integral part of the CMS Medicare and Medicaid programs. It is used to assess the performance of health care providers and organizations, and to help improve the quality of care.

What is quality reporting?
Health care providers report quality measures to CMS about the care they provide to Medicare beneficiaries. These measures are tools that help CMS assess various aspects of care, including patients' health outcomes, processes of care, and organizational structure. The measures reported by providers help CMS form an idea of how well health care providers are performing in their goal of providing effective, efficient, patient-centered, equitable, and timely care.

How does quality reporting impact you?
By reporting quality measures, clinicians can:
- Improve the care they provide to their patients
- Improve their patient satisfaction
- View their published quality metrics alongside that of their peers on the Physician Compare websites
- Avoid payment reductions
- Avoid payment adjustments
- Avoid payment restrictions
- Avoid payment adjustments based on performance

FOLLOW THIS ROAD MAP
Follow this road map to ensure you are participating in CMS quality programs and achieving the potential benefits the programs offer to both you and your patients.
REPORTING MECHANISM OPTIONS BY PRACTICE SIZE

Determine Eligibility
In order to participate in 2016 PQRS to avoid the Medicare payment adjustments you need: First determine eligibility, then inform your patients how to determine your eligibility. For the 2016 list of
Eligible Professionals, available on the PQRS How to
CMS website.

The reporting period for 2016 is:

January 1, 2016 - December 31, 2016

Choose Your Reporting Mechanism
You can use the CMS How to Guide to select the measurement and reporting systems that outline your chosen reporting mechanisms.

- Claims Reporting
- EMR/Practice Management
- Electronic Reporting Using CQI
- Global Peer Review System
- Group Practice Reporting System Web Interface

Select and Report Your Measures
The 2016 PQRS measures are as follows; strategic goals,这样 as the measures focus, and procedure-related care.

See the 2016 Measures List, available on the PQRS website at: http://www.pqi.org/Website.

Choose your measuring methodology to display in the quality measures used to determine the measure performance.

Why should you participate in CMS quality initiatives?
Participation in CMS quality initiatives can help:
- Reduce quality of care for Medicare beneficiaries. Through PQRS, individual eligible professionals and group practices report quality measures to ensure CMS is able to achieve its goals.
- Reduce costs and improve overall quality of care by focusing on the most important clinical issues and promoting evidence-based policies and practices.
- Reduce costs and improve overall quality of care by focusing on the most important clinical issues and promoting evidence-based policies and practices.
- Enhance your organization’s reputation and position your practice at the forefront of improvement efforts.

CMS: The data you report for PQRS is used for:

- Value Modifier
- Physician Compare

Value Modifier
PQRS data are used to calculate the Value Modifier for practices and certain providers in 2016.
- The 2016 Value Modifier is based on data from the 2015 reporting period. For 2016, the value modifier will apply to measures used to determine the Medicare EHR incentive program participation.
- The value modifier is based on the value modifier for practices and certain providers in 2015, which will be the same as the 2016 value modifier.
- In order to be eligible for upward adjustment, a practice must report on both the quality measure and the value modifier. For 2016, the value modifier will be based on the value modifier for practices and certain providers in 2015, which will be the same as the 2016 value modifier.

Physician Compare
Several PQRS measures are publicly reported on Physician Compare, including:
- The value modifier for providers in groups with 2 or more EQaPs.
- The value modifier for providers in groups with 2 or more EQaPs.
- The value modifier for providers in groups with 2 or more EQaPs.
- The value modifier for providers in groups with 2 or more EQaPs.
- The value modifier for providers in groups with 2 or more EQaPs.

3
How Does the Program Work?

The EHR Incentive Program consists of 3 stages.

– Stage 1: Data Capture & Sharing
– Stage 2: Advanced Clinical Processes
– Stage 3: Improved Outcomes

Each stage will have its own set of requirements to meet in order to demonstrate meaningful use.

We are currently in Stage 1. The requirements in Stage 1 are focused on providers capturing patient data and sharing that data either with the patient or with other healthcare professionals.
What Were the Requirements Before 10/2015 Changes?

In addition to meeting the thresholds for the 15 core and 5 menu objectives, all eligible professionals have to report on Clinical Quality Measures.

We’ll review the Clinical Quality Measures later, but for now you should know that Clinical Quality Measures are different from core and menu objectives.

There are no thresholds to meet for Clinical Quality Measures—you simply report the data exactly as it is calculated by your certified EHR.

Original Table:

<table>
<thead>
<tr>
<th>Meaningful Use</th>
<th>15 + 5 + 6 = MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Measures</td>
<td>Menu Measures</td>
</tr>
<tr>
<td>CQMs</td>
<td>Meaningful Use</td>
</tr>
</tbody>
</table>

Originally, There Were -

Meaningful Use: 15 Core Objectives

Below are the 15 core objectives that every eligible professional must meet in order to receive an EHR Incentive Payment.

1. Computerized provider order entry (CPOE)
2. Drug-drug and drug-allergy checks
3. Maintain an up-to-date problem list of current and active diagnoses
4. E-Prescribing (eRx)
5. Maintain active medication list
6. Maintain active medication allergy list
7. Record demographics
8. Record and chart changes in vital signs
9. Record smoking status for patients 13 years or older
10. Report ambulatory clinical quality measures to CMS/States
11. Implement clinical decision support
12. Provide patients with an electronic copy of their health information, upon request
13. Provide clinical summaries for patients for each office visit
14. Capability to exchange key clinical information
15. Protect electronic health information
## Meaningful Use: 10 Menu Objectives

- You have to report on 5 of these 10 menu objectives.
- At least one of the 5 you report must be a Public Health objective.

Once you understand the program basics, we encourage you to explore our Meaningful Use Specification Sheets (https://www.cms.gov/EHRIncentivePrograms/Downloads/EPMU-TOC.pdf), which give in-depth information on each of the objectives, including how to calculate numerators and denominators, definitions of important terms, and additional information about achieving the objectives.

### When selecting your 5 menu objectives, at least one must come from the Public Health list, which consists of the following:

1. Submit electronic data to immunization registries.

   OR

2. Submit electronic syndromic surveillance data to public health agencies.
Meaningful Use: 10 Menu Objectives

After you have selected a public health objective, you still have to choose 4 more menu objectives to report. You can select any 4 from the list below—or you could report on both public health objectives and choose 3 from the list below:

3. Drug formulary checks
4. Incorporate clinical lab-test results
5. Generate lists of patients by specific conditions
6. Send reminders to patients for preventive/follow-up care
7. Patient-specific education resources
8. Electronic access to health information for patients
9. Medication reconciliation
10. Summary of care record for transitions of care

Clinical Quality Measures

You will have to report on:

• 3 core clinical quality measures AND
• 3 clinical quality measures that you select from an additional list

You select the 3 additional clinical quality measures based on their relevance to your scope of practice. If you don’t collect information on one or more of the 3 core clinical quality measures, you can choose one or more replacements from an alternate core list.
Core Clinical Quality Measures

Here are the 3 core clinical quality measures that everyone must report on:

<table>
<thead>
<tr>
<th>Clinical Quality Measure Title</th>
<th>NQF Measure Number &amp; PQRI Implementation Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension: Blood Pressure Measurement</td>
<td>NQF 0013</td>
</tr>
<tr>
<td>Preventive Care and Screening Measure Pair:</td>
<td></td>
</tr>
<tr>
<td>a) Tobacco Use Assessment</td>
<td>NQF 0028</td>
</tr>
<tr>
<td>b) Tobacco Cessation Intervention</td>
<td></td>
</tr>
<tr>
<td>Adult Weight Screening and Follow-up</td>
<td>NQF 0421 PQRI 128</td>
</tr>
</tbody>
</table>

THEN CAME THE NEWS!

OCTOBER 6, 2015

EHR INCENTIVE PROGRAM AND HEALTH IT PROGRAM FINAL RULE
Fact Sheet – EHR Incentive Program 10/06/2015

• Shared goals of program:
  – Building a health care system that delivers better care, spends health care dollars more wisely, and makes our communities healthier – all with the patient at the center of their care”. (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Face-sheets/2015-Fact-sheets-items/2015-10-16.html.)
  – Electronic health records critical to this effort.
  – EHRs “offer providers easy access to patient information, a series of tools, such as clinical alerts and reminders to support clinical decisions; enhanced communication with other clinicians, labs, and health plains; documentation that facilitates accurate coding and billing, and safer, more reliable prescribing.”
  – EHRs benefits patients in accomplishing “less paperwork, reminders of important health interventions, convenience of e-prescriptions, and an avenue for communication with providers.”

According To CMS –
“We have made progress but have more work to do.”

• Over past years an increasing number of physicians, clinicians and hospitals are using EHRs to improve patient care:
  – More than 70% of Eligible Physicians/other clinicians; and
  – More than 95% of Eligible Hospitals have successfully used EHRs and received incentive payments from the federal government.
  – CMS listening to comments from physicians and other providers about challenges they face making the technology work well in practice.
  – Physician, in particular, have expressed ongoing concern over increasing requirements for use of EHR and frustration at competing reporting requirements among programs.
  – Providers have also described challenge of planning for and reporting complex and numerous meaningful use requirements.
  – In recognition of these concerns, CMS announcing significant changes in current requirements and will ease burden of reporting, continue to support interoperability and patient outcomes.
How Will Changes Accomplish New Goals?

• By providing simplicity and flexibility – in order “that providers can choose the measures of progress that are most meaningful for their practices.”
  – Commenters asked CMS to reduce burden and duplicative reporting, including reporting on measures that are irrelevant to their specialty.
    • CMS is reducing number of objectives from 20 to less than 10 and are providing flexibility so providers may choose measures most relevant to their practice.
    • CMS also aligning certain aspects of reporting of clinical quality measures with other CMS Medicare quality reporting programs, enabling providers to report once and receive credit for multiple programs.

How Will Changes Accomplish New Goals?

– Commenters asked CMS to give adequate time to implement changes to program requirements:
  • CMS is allowing 90 day reporting for all providers in 2015, extending the 90 day reporting period to new providers in 2016 and 2017, and to everyone choosing to adopt 2018 measures a year early.
  • CMS giving providers and states more time – 27 months, until January 1, 2018 – to comply with new requirements and prepare for next set of system improvements
  • Giving Developers more time to create next advancements in technology that will be easier to use and more appropriate to new models of care and access to data by consumers.
What Do Changes Mean for Providers?

- In 2016 and 2017 for both Medicare and Medicaid providers (and 2018 for Medicaid providers):
  - Those providers new to EHR Incentive Program have additional flexibility and can report on any 90 days.
  - "Health care providers are actively working to improve the way they deliver care by using technology today, and change takes time, so most changes are required until 2018, allowing time to plan."
  - For those ready to move forward, they can transition to next phase in 2017.
  - For Medicare providers experiencing difficulty, CMS encourages applying for hardship exceptions, which are reviewed on a case-by-case basis.
    - For example, providers switching EHR vendors or who have other technology difficulties may be eligible for a Hardship Exception.
    - Don't Miss It! - Deadline for filing Hardship Exception has been extended until July 1, 2016. Refer to AMA website for additional information.

<table>
<thead>
<tr>
<th>Eligible Professional Objectives and Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.</td>
</tr>
<tr>
<td>(2) Use clinical decision support to improve performance on high-priority health conditions.</td>
</tr>
<tr>
<td>(3) Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. Generate and transmit permissible prescriptions electronically (eRx).</td>
</tr>
<tr>
<td>(4) Health Information Exchange - The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral. Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</td>
</tr>
<tr>
<td>(5) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</td>
</tr>
<tr>
<td>(6) Patient electronic access - Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</td>
</tr>
<tr>
<td>(7) Use secure electronic messaging to communicate with patients on relevant health information.</td>
</tr>
<tr>
<td>(8) Public Health Reporting - The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.</td>
</tr>
</tbody>
</table>

View or download all of the EP modified objectives and measures for meaningful use in 2016.
System Announcements Effective May 03, 2016:

EHR Program Announcement - The CMS Medicare Attestation System will be open and fully operational, for providers new to the Medicare EHR Incentive Program, to attest for the 2016 program year beginning July 5, 2016. If you are an eligible professional beginning participation in the Medicare EHR Incentive Program, you may attest for any 90 day continuous reporting period within the calendar year.

EHR Program Announcement - Visit the Registration Tab to ensure your information is accurate, such as the Payee selection and email address. The EHR incentive program communicates to you using the email address on file on the Personal Information page of the Registration & Attestation website.

EHR Program Announcement - Hospital Based Status - New EPs - To determine your hospital based status contact the information center at (888) 734-6433 and choose option 1 for the EHR Incentive Program and option 4 in the interactive voice response system (IVR). Existing EPs - review and resubmit your registration to determine your status.

Don’t Miss the Deadline!

2017 MEDICARE EHR INCENTIVE PROGRAM PAYMENT ADJUSTMENT
HARDSHIP EXCEPTION APPLICATION
The submission deadline is 11:59PM ET on July 1, 2016.

SECTION 1. APPLICANT INFORMATION
Section 1.1 - Provide the information below for the person working on behalf of the provider to apply for the hardship exception. (Fields marked with * are required.) Provide required information for each provider in Section 3 and/or 4.

<table>
<thead>
<tr>
<th>First Name*</th>
<th>Last Name*</th>
<th>Suffix</th>
<th>Company or Organization Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email Address (This is how we will communicate with you).*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Telephone Number (Include Area Code)*</td>
<td>Extension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address (Street Name and Number - Not a Post Office Box)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/Town*</td>
<td>State* (2 character code)</td>
<td>Zip Code (5 digits)*</td>
<td></td>
</tr>
</tbody>
</table>
CMS INCENTIVE PROGRAMS

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) 2016

2016 Physician Quality Reporting System (PQRS) List of Eligible Professionals

Eligible Professionals
Under PQRS, an eligible professional (EP) is defined as one of the following types of professionals:

1. Medicare physicians
   Doctor of Medicine
   Doctor of Osteopathy
   Doctor of Podiatric Medicine
   Doctor of Optometry
   Doctor of Oral Surgery
   Doctor of Dental Medicine
   Doctor of Chiropractic

2. Practitioners
   Physician Assistant
   Nurse Practitioner*
   Clinical Nurse Specialist*
   Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant)
   Certified Nurse Midwife*
   Clinical Social Worker
   Clinical Psychologist
   Registered Dietician
   Nutrition Professional
   Audiologist*

   *Includes Advanced Practice Registered Nurse (APRN)

3. Therapists
   Physical Therapist
   Occupational Therapist
   Qualified Speech-Language Therapist
Who is eligible to participate in PQRS?

Medicare physicians, practitioners, and therapists providing covered professional services paid under or based on the MPFS are considered EPs under PQRS. To the extent that EPs are providing services which get paid under or based on the MPFS, those services are eligible for PQRS negative payment adjustments. Individual EPs, EPs in PQRS group practices, Accountable Care Organizations (ACOs) reporting PQRS via the GPPRO Web Interface, and Comprehensive Primary Care (CPC) practice sites are eligible to participate in PQRS. View the complete “2016 PQRS List of Eligible Professionals” (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN] combination) on the PQRS How To Get Started webpage.

Why should I participate in PQRS?

- Help improve health care quality. Driving quality improvement is a core function of CMS. The vision for the CMS Quality Strategy is to optimize health outcomes by leading clinical quality improvement and health system transformation. PQRS plays a crucial role to facilitate physician participation in this process committed to quality improvement.
- Be a satisfactory reporter and avoid the 2016 PQRS negative payment adjustment. Additional information on how to avoid the PQRS negative payment adjustment can be found in this guide and supporting documentation on the CMS PQRS website.

What are quality measures?

Quality measures are indicators of the quality of care provided by physicians. They are tools that help CMS measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care. Refer to page 7 for more information on quality measures.

It is important to review and understand each measure specification especially as it pertains to a specific reporting mechanism. The measure specification specific to the reporting mechanism will provide definitions and specific instructions for satisfactorily reporting the measure. This guide provides a web address under each reporting mechanism for easy location of the measures specifications. Refer to the next section, “PQRS Measure Selection Considerations,” for more information about denominators and numerators. Also refer to Appendix A, Glossary of Terms, which further defines the terms denominator and numerator as well as other terms commonly used in PQRS.
The 2016 PQRS measures address various aspects of care, such as prevention, chronic and acute-care management, procedural-based care, resource utilization, and care coordination. EPs and PQRS group practices are required to report on all of the PQRS measures and must select which measures they would like to report.

### How should I determine which measures to report?

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Review the Measures List</td>
<td>Review the &quot;2016 Physician Quality Reporting System (PQRS) Measures List&quot; and the PQRS Web-Based Measure Search Tool, available on the PQRS Measures Codes website, to determine which measures, associated domains, and domains are available under each PQRS reporting mechanism. EPs or group practices should avoid individual measures that do not or may infrequently apply to the services they provide to Medicare patients.</td>
</tr>
</tbody>
</table>
| Step 2: Consider important factors | Consider the following factors when selecting measures for reporting:
- Clinical conditions usually treated
- Types of care typically provided — e.g., preventive, chronic, acute care
- Settings where care is usually delivered — e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2016
- Other quality reporting programs in use or being considered by the NQS (see further explanation below). |
| Step 3: Review specifications | After making a selection of potential measures, review the specifications for the selected reporting mechanism for each measure under consideration. Select those measures that apply to services most frequently provided to Medicare patients by the EP or PQRS group practice. EPs or PQRS group practices should review each measure's denominator coding to determine which patients may be eligible for the selected PQRS measures. EPs can report individual measures or groups of measures. EPs or group practices cannot select individual measures or all of the measures within the PQRS Web Interface, if that mechanism is chosen. Group practices must report using an EMP, registry, CCQR, or via the PQRS Web Interface in order to select their measures. |

The National Quality Strategy (NQS)

In 2016, measures are classified according to the 6 NQS domains based on the NQS’s priorities. PQRS reporting mechanisms typically require an EP or PQRS group practice to report 5 or more measures covering at least 3 NQS domains, and cross-cutting measures for the NQS with specialties. EPs can report individual measures or groups of measures. EPs or group practices cannot select individual measures or all of the measures within the PQRS Web Interface, if that mechanism is chosen. Group practices must report using an EMP, registry, CCQR, or via the PQRS Web Interface in order to select their measures.

### The Six NQS Domains

- Patient Safety
- Person and Caregiver-Centered Experience and Outcomes
- Effective Clinical Care
- Communication and Care Coordination
- Community/Population Health
- Efficiency and Cost Reduction

#### What is a measure?

Measures consist of two major components: denominators and numerators.

**PQRS Denominators and Numerators**

- **Numerator**
  - The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality of clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or unit of measurement established by the denominator (such as providers that completed a specific outcome or process).

- **Denominator**
  - The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should include age, condition, setting, and timeframe (when applicable). For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.”

Each component is defined by specific codes described in the respective measure's specification along with the reporting instructions and use of modifiers.
I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

(Refer to the 2016 Physician Quality Reporting System Measures List for a listing of all 2016 measures and associated NQS domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)

SELECT REPORTING MECHANISM

IF ≥ 9 MEASURES COVERING ≥ 3 NQS DOMAINS APPLY, REPORT ON ≥ 3 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

Of these measures, if an EHR sees at least one EHR patient in a domain to report on, report on at least 1 cross-cutting measure set.

AND

Report each measure for at least 50% of the applicable medication Part 9 FTS patients.

Measures with a ≥ 9% performance rate will not be counted.

12 MONTHS

IF ≥ 9 MEASURES COVERING ≥ 3 NQS DOMAINS APPLY, REPORT ON ≥ 3 INDIVIDUAL MEASURES COVERING ≥ 3 OR MORE NQS DOMAINS.

Of these measures, if an EHR sees at least one EHR patient in a four-to-five encounter, the EHR is required to report on at least 1 cross-cutting measure set.

AND

Report each measure for at least 50% of the applicable medication Part 9 FTS patients.

Measures with a ≥ 9% performance rate will not be counted.

12 MONTHS

QUALIFIED CLINICAL DATA REGISTRY REPORTING

QUALIFIED REGISTRY REPORTING

GROUP PRACTICE REPORTING OPTION

ELECTRONIC REPORTING USING AN EHR

QUALIFIED REGISTRY REPORTING OPTIONS FOR AVOIDING 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM

INDIVIDUAL MEASURES

IF ≥ 9 MEASURES COVERING ≥ 3 NQS DOMAINS APPLY, REPORT ON ≥ 3 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

Of these measures, if an EHR sees at least one EHR patient in a domain to report on, report on at least 1 cross-cutting measure set.

AND

Report each measure for at least 50% of the applicable medication Part 9 FTS patients.

Measures with a ≥ 9% performance rate will not be counted.

12 MONTHS

IF ≥ 9 MEASURES COVERING ≥ 3 NQS DOMAINS APPLY, REPORT ON ≥ 3 INDIVIDUAL MEASURES COVERING ≥ 3 OR MORE NQS DOMAINS.

Of these measures, if an EHR sees at least one EHR patient in a four-to-five encounter, the EHR is required to report on at least 1 cross-cutting measure set.

AND

Report each measure for at least 50% of the applicable medication Part 9 FTS patients.

Measures with a ≥ 9% performance rate will not be counted.

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QUALIFIED REGISTRY REPORTING

GROUP PRACTICE REPORTING OPTION

ELECTRONIC REPORTING USING AN EHR

QUALIFIED REGISTRY REPORTING

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3/1/2016
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3/1/2016
Page 21 of 29
I WANT TO PARTICIPATE IN 2016 PQRS TO AVOID THE 2018 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING MECHANISM
(Refer to the 2016 Physician Quality Reporting System Measures List for a listing of all 2016 measures and associated NQF domains for a specific reporting mechanism. Also review the appropriate measure specifications for the selected reporting mechanism(s) for 2016 PQRS)

REPORT ON A QUALIFIED REGISTRY - 3 NQF DOMAINS
- If an EP reports more than one measure on a patient day for a domain, the measure with the best possible score that day will be counted.
- For measures not scored on a patient day, the first occurrence is counted to avoid double-counting.
- A score of 100 is required to achieve full credit for a domain.
- A grade of 0 indicates that the EP has not submitted data for at least one domain.
- A score of less than 100 for a domain will result in a payment adjustment.

12 MONTHS
- Required by June 30, 2016

REPORT ON AN EHR OPTIONS TO AVOID 2016 PQRS NEGATIVE PAYMENT ADJUSTMENT

REPORT ON AN EHR OPTIONS TO AVOID 2016 PQRS NEGATIVE PAYMENT ADJUSTMENT

REPORT ON AN EHR OPTIONS TO AVOID 2016 PQRS NEGATIVE PAYMENT ADJUSTMENT

REPORT ON AN EHR OPTIONS TO AVOID 2016 PQRS NEGATIVE PAYMENT ADJUSTMENT

REPORT ON AN EHR OPTIONS TO AVOID 2016 PQRS NEGATIVE PAYMENT ADJUSTMENT
CMS INCENTIVE PROGRAMS - CONTINUED

VALUE BASED MODIFIER (VM)
“Value Based Modifier”

- Adjusts payments to a physician or group of physicians identified by their TIN:
  - Based on the Quality and Cost of Care furnished to their Medicare Fee-for-Service (FFS) beneficiaries.
  - Section 3007 of the 2010 Patient Protection and Affordable Care Act (ACA) directed Secretary of DHHS to establish a budget-neutral Value-Based Payment Modifier (VM) that provides differential payment based on the quality of care compared to the cost of care furnished during a performance period.
  - The VM is separate from the payment adjustment and incentives under the PQRS.
  - Beginning 01/01/2015, the VM was applied to physician payments under the Medicare PFS for physicians in TINs with 100 > eligible professionals if at least 1 physician submitted a Medicare claim during 2013 under the TIN. (2013 was the performance period for the VM that was applied in 2015).
Beginning 01/01/2016

- **Value Modifier applied to physician payments under Medicare PFS for physicians in TINs with 10> eligible professionals:**
  - If at least one physician submitted a Medicare claim during 2014 under the TIN.
  - CY 2014 is performance year for the VM applied in 2016.

- In 2015 and 2016, CMS will not apply VM to TINs in which one or more physicians in the TIN participated in the Medicare Shared Savings Program (MSSP), The Pioneer Accountable Care Organization (ACO) Model, or the Comprehensive Primary Care (CPC) initiative during the relevant reporting period.

2016 Value Modifier Divided Into Two Categories

- Based on their registration and participation in the PQRS 2014 performance period:
  - **Category I** – Includes TINs that **met criteria** as a group to avoid 2016 PQRS payment adjustment or in which at least 50% of EPs in TIN met criteria to avoid 2016 PQRS payment adjustment as individuals.
    - For TINs in Category I, the 2016 VM will be calculated based on TINs quality and cost performance in 2014, using CMS's quality-tiering methodology.
  - **Category II** – Includes TINs subject to 2016 VM **that do not meet criteria** for inclusion in Category I.
    - For Category II TINs, the 2016 VM will be set at -2.0% (downward payment adjustment) based on 2014 performance period reporting.
    - The VM payment adjustment applies in addition to any PQRS negative payment adjustment the TIN or individual EPs in the TIN may incur.
Beginning 01/01/2017

- VM will be applied to physician payments under Medicare PFS for:
  - Physician solo practitioners and physicians in groups with two or more eligible professionals, identified by their TIN.
  - CY 2015 is performance period for the VM that will be applied in 2017.
  - CMS provides specific policies regarding application of VM to TINs participating in MSSP ACOs, Pioneer ACOs, the CPC initiative and other similar initiatives.

Higher Incentives/Higher Risk?

- Under quality tiering all TINs with 10+ EPs can earn an upward payment adjustment (demonstrating higher quality and/or lower cost).
- Each year must be budget-neutral:
  - Size of upward adjustment will be based on adjustment factor (AF) calculated to redistribute downward adjustments from low-performing TINs and Category II TINs to the higher-performing TINs.
  - Precise size of the AF will vary from year to year based on performance, reporting status, and projected billings.
  - Higher-performing TINs that treat high-risk beneficiaries are also eligible for an additional upward payment adjust of +1.0 times the AF.
Physicians in Category I

- **TINs with 10 to 99 EPs could receive:**
  - An upward or neutral (meaning no adjustment) adjustment, and
  - Will be held harmless from any downward payment adjustment in 2016.

- However, Physicians in TINs with 100+ EPs can receive an upward, neutral, or downward adjustment in 2016 based on the TINs performance on quality and cost measures in 2014.

**Quality and Cost Composite Calculations**

- Quality and Cost Composite Scores using for quality-tiering summarize each TINs performance on quality measures:
  - Across 6 quality domains, and
  - Cost measures across 2 cost domains.

- For information on the measures included in each domain, please see the Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report (QRUR) available at:
### QUALITY AND COST DOMAINS

<table>
<thead>
<tr>
<th>QUALITY DOMAINS</th>
<th>COST DOMAINS</th>
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<tbody>
<tr>
<td>1. Effective Clinical Care</td>
<td>1. Per Capita Costs for All Attributed Beneficiaries</td>
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<tr>
<td>2. Person and Caregiver-Centered Experience and Outcomes</td>
<td>2. Per Capita Costs for Beneficiaries with Specific Conditions</td>
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<tr>
<td>3. Community/Population Health</td>
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<td>4. Patient Safety</td>
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<td>5. Communication and Care Coordination</td>
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<tr>
<td>6. Efficiency and Cost Reduction</td>
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Accessing Your Quality Reporting Use Report (QRUR)

In April 2016, Centers for Medicare & Medicaid Services (CMS) made available the 2015 Mid-Year Quality and Resource Use Reports (QRURs) to group practices and solo practitioners nationwide, including those that are participants in the Comprehensive Primary Care (CPC) initiative, the Shared Savings Program (SSP), or the Pioneer Accountable Care Organization (ACO) Model. Groups and solo practitioners are identified in the QRURs by their Medicare-enrolled Taxpayer Identification Number (TIN). The performance period for the 2015 Mid-Year QRUR and the 2015 annual QRUR.
Accessing Your Quality Reporting Use Report (QRUR)

The following information is not included in the 2015 Mid-Year QRUR:

1. Quality composite and cost composite scores for the 2017 VM
2. Group or individually reported Physician Quality Reporting System (PQRS) data (including Consumer Assessment of Healthcare Providers and Systems (CAHPS))
3. Information about the 2017 VM payment adjustment

More information about the 2015 Mid-Year QRURs and the VM is available at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html

This Quick Reference Guide (QRG) illustrates how to access and download a 2015 Mid-Year QRUR, along with the Tables from CMS Enterprise Portal. 2015 Mid-Year QRURs (including a 508 compliant version) and Tables can be downloaded and exported in Portable Document Format (PDF) or Excel Format, respectively. The data in the 2015 Mid-Year QRURs is also available for download to an exportable Comma-Separated Values (CSV) file.
APRIL, 2016 (TO BE PUBLISHED IN FEDERAL REGISTER ON MAY 9, 2016)
NEWS FLASH! LATEST NEWS FROM CMS ON INCENTIVE PROGRAMS!

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 414 and 495
[CMS-5517-P]
RIN 0938-AS69
Medicare Program: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Proposed rule.
MACRA 2016

- Medicare Program: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule (PFS) – Proposed rule – 42 CFR Parts 414 and 495 [CMS-5517-P]:

- Summary:
  - Repealed Medicare Sustainable Growth Rate (SGR) Methodology for updates to PFS
  - Replaces it with new Merit-Based Incentive Payment System (MIPS) for eligible Clinicians (was Professionals) or groups under PFS.
  - For Medicare-enrolled practitioners
  - MIPS to consolidate three existing programs – PQRS, Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals.
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:** 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:** Medicare fee-for-service payments are tied to quality or value (categories 3-4) 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:

- **2016**
  - 30%
- **2018**
  - 85%
  - 90%

Legend:

- 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
...and toward transforming our health care system.

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on 3 areas

- Incentives
- Care Delivery
- Information Sharing

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

Are there any exceptions to MIPS adjustments?

There are 3 groups of physicians and practitioners who will NOT be subject to MIPS:

- FIRST year of Medicare participation
- Participants in eligible Alternative Payment Models who qualify for the bonus payment
- Below low volume threshold

Note: MIPS does not apply to hospitals or facilities
Alternative Payment Models (APMs)

APMs are new approaches to paying for medical care through Medicare that incentivize quality and value.

- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by Federal Law

According to MACRA law, APMs include:

- MACRA does not change how any particular APM rewards value.
- APM participants who are not “QPs” will receive favorable scoring under MIPS.
- Only some of these APMs will be eligible APMs.

How does MACRA provide additional rewards for participation in APMs?

Most physicians and practitioners who participate in APMs will be subject to MIPS and will receive favorable scoring under the MIPS clinical practice improvement activities performance category.

Those who participate in the most advanced APMs may be determined to be qualifying APM participants (“QPs”). As a result, QPs:
1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update for 2026 and onward
What is an eligible APM?

Eligible APMs are the most advanced APMs that meet the following criteria according to the MACRA law:

- Base payment on quality measures comparable to those in MIPS
- Require use of certified EHR technology
- Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority

How do I become a qualifying APM participant (QP)?

QP: Are not subject to MIPS
QP: Receive 5% lump sum bonus payments for years 2019-2024
QP: Receive a higher fee schedule update for 2026 and onward

QP: Are physicians and practitioners who have a certain % of their patients or payments through an eligible APM.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid.
Potential value-based financial rewards

- APMs—and eligible APMs in particular—offer greater potential risks and rewards than MIPS.
- In addition to those potential rewards, MACRA provides a bonus payment to providers committed to operating under the most advanced APMs.

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<thead>
<tr>
<th>MIPS only</th>
<th>APMs</th>
<th>eligible APMs</th>
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<tr>
<td>MIPS adjustments</td>
<td>APM-specific rewards + MIPS adjustments</td>
<td>eligible APM-specific rewards + 5% lump sum bonus</td>
</tr>
</tbody>
</table>

Examples of Alternative Payment Models

- Comprehensive ESRD Care Model
- Health Care Innovation Awards
- Health Care Innovation Awards – Round 2
- Incentives for Prevention of Chronic Disease in Medicaid Demonstration
- Multi-payer Advanced Primary Care Program
- ACO Investment Model
- Advance Payment ACO Model
- Comprehensive Primary Care Initiative
- Pioneer ACO Model
- Strong Start for Mothers and Newborns Initiative
Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Encourage new APM options for Medicare physicians and practitioners.

Submission of model proposals → Technical Advisory Committee (11 appointed care delivery experts) → Secretary comments on CMS website, CMS considers testing proposed model

Review proposals, submit recommendations to HHS Secretary

What should I do to prepare for MACRA?


• Look for a proposed rule in spring 2016 and provide comments on the proposals.

• Final rule targeted for early fall 2016.
Comment Period for Proposed Rule

• To be assure consideration, comments must be received (refer to file code CMS-5517-P) - No later than 3 p.m. on June 27, 2016:


2. By regular mail – Mail to the following address ONLY:
   • Centers for Medicare & Medicaid Services,
     Attention: CMS-5517-P,
     P.O. Box 8013
     Baltimore, MD 21244-8013

Comment Period for Proposed Rule

3. By express or overnight mail a the following address ONLY:
   • Centers for Medicare & Medicaid Services
     Department of Health and Human Services
     Attention: CMS-5517-P
     Mail Stop C4-26-05
     7500 Security Boulevard
     Baltimore, MD 21244-1850

4. By hand or courier or you may deliver (by hand or courier) your written comments ONLY to the following address:
   a. For delivery to Washington, DC - Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201
   b. For delivery to Baltimore, MD – CMS, Dept of HHS, 7500 Security Boulevard, Baltimore, MD 21244-1850. Call telephone number in advance to schedule your arrival with one of our staff members at 410-786-7195.
Other Information In Relation to Proposed Rule

• For further information contact:
  – Molly MacHarris, 410-786-4461 – for inquiries related to MIPS,
  – James P. Sharp, 410-786-7388 – for inquiries related to APMs.

• Supplementary information:
  – Inspection of Public Comments – All comments received before close of comment period are available for viewing by public, including any personally identifiable or confidential business information that is included in a comment.
  – We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.
  – Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of CMS, 7500 Security Boulevard, Baltimore, MD, 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Summary - Continued

• Proposed rule to:
  – Sunset payment adjustments under current PQRS, VM, and Medicare EHR Incentive Program for EPs. Components of 3 programs would be carried forward into new MIPS program.
  – Define MIPS program participants as “MIPS eligible clinicians”
    • To include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include such clinicians with proposed definitions and requirements for groups.
  – Also proposes rules for specific Medicare-enrolled practitioners that would be excluded from MIPS:
    – Newly Medicare-enrolled eligible clinicians,
    – Qualifying APM Participants (QPs),
    – Certain Partial Qualifying APM Participants (Partial QPs), and
    – Clinicians that fall under the proposed low-volume threshold.
MIPS Performance Standards

• Rule proposes MIPS performance standards:

  performance period of 1 calendar year – January 1 through December 31 for all measures and activities applicable to the four performance categories.

  – Further, propose to use full year reporting period of 2017 as 1st performance period for 2019 payment adjustment.

  – Proposes measures, activities, reporting, and data submission standards across four performance categories.

1. Quality

  – Includes a minimum of 6 measures with at least one cross-cutting measure (for patient-facing MIPS eligible clinicians); and

  – An outcome measure, if available;

    » If not available, then EC (Eligible Clinician) would report one other high priority measures (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure.

    » MIPS eligible clinicians can meet this criterion by selecting measures either individually or from a specialty-specific measure set.
MIPS Performance Standards

2. Resource use –
   – Continuation of 2 measures from VM:
     » Total per costs capita for all attributed beneficiaries; and
     » Medicare Spending per Beneficiaries (MSPB) with minor technical adjustments.
     » In addition, episode-based measures, as applicable to the MIPS EC.

3. Clinical Practice Improvement activities (CPIAs) –
   – CMS encourages but are not requiring a minimum number of CPIAs.

MIPS Performance Standards

4. Meaningful use of certified EHR technology (referred to in this proposed rule as “Advancing Care Information”).
   – Measures and activities would vary by category and include outcome measures, performance measures, and global and population-based measures.
   – Consideration would be given to the application of measures to non-patient facing MIPS eligible clinicians.
MIPS Performance Standards

• CMS proposes standards for performance in all four categories outlined.
• CMS proposes MIPS Eligible Clinicians who participate in certain types of APMs will be scored using an APM scoring standard instead of the generally applicable MIPS scoring standard.

Medicare Threshold For Level Of Participation In Advanced APMS

• To become a QP for a year:
  – The Medicare Option – based on Part B payments for covered professional services or counts of patients furnished covered professional services under Part B, is applicable beginning with CY 2019.
  – The All Payer Combination Option – based on the Medicare Option, as well as an eligible clinician’s participation in Other Payer Advanced APMs, is applicable beginning with CY 2021.
  – For a clinician to become QPs through the All-Payer Combination Option, and Advanced APM Entity or eligible clinician must submit information to CMS so that it can be determined whether the Other Payer APM is an Other Payer Advanced APM and whether a clinician meets the requisite QP threshold of participation. CMS proposes a methodology and criteria to evaluate a clinicians using the All-Payer Combination Option.
It Isn’t Just Medicare – Other Payers Are Also Involved

Fierce Health Payer – www.fiercehealthpayer.com
Payers positioned to lead alternative payment model transformation
Highmark, Capital BlueCross execs share what steps they’re taking to implement paying for value instead of volume
April 14, 2015 | By Dori Zweig

UNITED HEALTHCARE – UHCONLINE.COM
• Our involvement with value-based payments began over 30 years ago initially with capitated arrangements followed by Centers of Excellence programs. Over time, we have shifted to increased collaboration, outcomes based payment and new benefit designs to drive innovation in how we pay for health care and how it is delivered.
• We expanded our partnerships with physicians, hospitals, and provider organizations to support performance based programs including the new Comprehensive Primary Care Incentive models (CPCI), Patient-Centered Medical Homes (PCMHs), and Accountable Care Organizations (ACOs).
• By forging these relationships, we bring value to you, our customer, and continue to deliver a positive, affordable health care experience for your employees. UnitedHealthcare commitment is demonstrated by the 8 million fully insured members we under this new model already.
• What’s more, many self-funded customers have already committed their employees to value-based models as well.
• In 2014, the value-based model is the way we will approach contracting with most hospital and providers. By 2015, all fully insured and self-funded customers will participate.

CMS - Health Care Payment Learning and Action Network

• To help achieve better care, smarter spending, and healthier people, the Department of Health and Human Services (HHS) is working in concert with our partners in the private, public, and non-profit sectors to transform the nation’s health system to emphasize value over volume.
• HHS has set a goal (PDF) of tying 30 percent of Medicare fee-for-service payments to quality (PDF) or value through alternative payment models by 2016 and 50 percent by 2018.
• HHS has also set a goal of tying 85 percent of all Medicare fee-for-service to quality or value by 2016 and 90 percent by 2018.
• To support these efforts, HHS has launched the Health Care Payment Learning and Action Network to help advance the work being done across sectors to increase the adoption of value-based payments and alternative payment models.
Questions?

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp