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This presentation 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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No financial conflicts to disclose.
Size and Scope of CMS Responsibilities

• CMS is the largest purchaser of health care in the world.
• Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
• CMS covers 100 million people through Medicare, Medicaid, the Children’s Health Insurance Program; or roughly 1 in every 3 Americans.
• The Medicare program alone pays out over $1.5 billion in benefit payments per day.
• Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually.
Delivery System Reform will result in better health outcomes for older adults

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies
- Fee-For-Service Payment Systems

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency
CMS Program Authorities

CMS Quality Payment Program
Hospital Value-Based Purchasing
ESRD Quality Improvement Program
Skilled Nursing Facility
Home Health Agencies,

CMS

Value-based Purchasing
Payment
CMMI & Medicaid

Hospital Readmissions Reduction Program
Health Care Associated Conditions Program
Medicare Physician Fee Schedule
Physician Feedback Report Quality Resource Utilization Report

Care and Payment Model Tests
Accountable Care Organizations
Dual eligible demonstrations
Medicaid Section 1115 Waivers
Medicaid HCBS Programs
Medicaid State Plan Amendments

Targeted surveys
Quality Assurance Performance Improvement

Quality Improvement
Clinical Standards
Survey & Certification

Hospitals and PAC facilities,
Home Health Agencies, ESRD
Facilities, Hospices
Measure Development

QIOs
Hospital Innovation & Improvement Networks
ESRD Networks

Hospital Inpatient Quality, Hospital Outpatient
In-Patient Psychiatric Hospitals
Cancer hospitals, Ambulatory Surgical Centers
Nursing homes
Home Health Agencies
Long-term Care Acute Hospitals
In-patient rehabilitation facilities
Hospices
ESRD Facilities

Hospital Inpatient Quality, Hospital Outpatient
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Long-term Care Acute Hospitals
In-patient rehabilitation facilities
Hospices
ESRD Facilities
Clinical Workflow in Caring for Persons with or at risk of Dementia

Detection
Diagnosis
Care Planning
Detection of Any Cognitive Impairment

Statutorily required element of the AWV, added via rulemaking

Federal Register / Vol. 75, No. 228 / Monday, November 29, 2010 / Rules and Regulations

• Summary of CMS response to comments:
  – No nationally recognized screening tool for detection of cognitive impairments at present time.
  – Clinicians can use best clinical judgment in the detection and diagnosis of cognitive impairments.
  – We will continue to actively monitor advancements in screening, collaborate with USPSTF, and
  – We will consider revising this element if the evidence is sufficient and a standardized screening test becomes available.
The Preferred Road to Coverage

Provide adequate evidence that...

Diagnostics

✓ The **incremental information** obtained by new diagnostic technology compared to alternatives
✓ Changes **physician/clinician** recommendations
✓ Resulting in **changes in therapy**
✓ That **improve clinically meaningful health outcomes**

Therapeutics

✓ A **treatment strategy** using the new therapeutic technology compared to alternatives
✓ Leads to **improved clinically meaningful health outcomes**

In Medicare beneficiaries
<table>
<thead>
<tr>
<th>Procedure</th>
<th>CMS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual wellness visit, first visit</td>
<td>HCPCS G0438 and G0439</td>
</tr>
<tr>
<td>Annual wellness visit, subsequent visit</td>
<td>HCPCS G042</td>
</tr>
<tr>
<td>Welcome to Medicare exam</td>
<td>CPT code 99490 – cannot be billed during same month as: Transitional Care Management – CPT 99495 and 99496 Home Healthcare Supervision – HCPCS G0181 Hospice Care Supervision – HCPCS G9182 Certain ESRD services – CPT 90951-90970</td>
</tr>
<tr>
<td>Chronic care management</td>
<td>CPT code 99490 – cannot be billed during same month as: Transitional Care Management – CPT 99495 and 99496 Home Healthcare Supervision – HCPCS G0181 Hospice Care Supervision – HCPCS G9182 Certain ESRD services – CPT 90951-90970</td>
</tr>
<tr>
<td>Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment</td>
<td>HCPCS G0505 – cannot be billed with 90785 (Psych treatment complex interactive), 90791 (Psych diagnostic evaluation), 90792 (Psych diagnostic evaluation with medical services), 96103 (Psych testing administered by computer), 96120 (Neuropsych test administered w/computer), 96127 (Brief emotional/behavioral assessment), 99201- 99215 (Office/outpatient visits new patient), 99324-99337 (Domiciliary/rest home visits new patient), 99341-99350 (Home visits new patient), 99366-99368 (Team conference with patient by health care professional), 99497 (Advanced care plan 30 minutes), 99498 (Advanced care plan additional 30 minutes)</td>
</tr>
<tr>
<td>Care transitions</td>
<td>CPT Code 99495 – communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge CPT Code 99496 – communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of high complexity and a face-to-face visit within seven days of discharge</td>
</tr>
<tr>
<td>Advanced care planning</td>
<td>CPT code 99497 for the first 30 minutes, and 99498 for each additional 30 minutes</td>
</tr>
</tbody>
</table>
Dementia eCQMs

• Measures developed based on CMS request to examine evidence base and measurement gaps to develop de novo eCQMs related to dementia care

• Worked with CMS leadership, experts from the Veteran’s Administration and the Alzheimer’s Association to develop two measures intended to address quality of care for patients at risk of or who have cognitive impairment

1. Cognitive Impairment Assessment Among Older Adults (75 years and older) – CI Assessment

2. Documentation of a Health Care Partner for Patients with Dementia or Mild Cognitive Impairment – Health Care Partner
QUESTION: What are the critical data elements for cognition?
Bill passed on September 18, 2014, and signed into law October 6, 2014

The Act requires the submission of standardized patient assessment data elements by:
- Long-Term Care Hospitals (LTCHs): LCDS
- Skilled Nursing Facilities (SNFs): MDS
- Home Health Agencies (HHAs): OASIS
- Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

The Act specifies that data “… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…”.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over 140,000 clinician practices over the next four years to improve on quality and enter alternative payment models.

- Two network systems will be created:
  1) **29 Practice Transformation Networks**: peer-based learning networks designed to coach, mentor, and assist.
  2) **10 Support and Alignment Networks**: provides a system for workforce development utilizing professional associations and public-private partnerships.
Clinical Practice Leaders Have Already Charted the Pathway to Practice Transformation

<table>
<thead>
<tr>
<th>Traditional Approach</th>
<th>Transformed Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s chief complaints or reasons for visit determines care.</td>
<td>We systematically assess all our patients’ health needs to plan care.</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today.</td>
<td>Care is determined by a proactive plan to meet patient needs.</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory/skill of the doctor.</td>
<td>Care is standardized according to evidence-based guidelines.</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care.</td>
<td>A prepared team of professionals coordinates a patient’s care.</td>
</tr>
<tr>
<td>Clinicians know they deliver high-quality care because they are well trained.</td>
<td>Clinicians know they deliver high-quality care because they measure it and make rapid changes to improve.</td>
</tr>
<tr>
<td>It is up to the patient to tell us what happened to them.</td>
<td>You can track tests, consults, and follow-up after the emergency department and hospital.</td>
</tr>
</tbody>
</table>

TCPI PTN WI: Mayo Clinic: Contact - Dr. Nilay Shah 507-266-5130, Diane Olson 507-293-5759, shah.nilay@mayo.edu; olson.diane9@mayo.edu

Adapted from Duffy, D. (2014). School of Community Medicine, Tulsa, OK.
**Question:** Which of the Areas are most critical to you, and why?

<table>
<thead>
<tr>
<th>Area</th>
<th>Meaningful Measure Areas</th>
</tr>
</thead>
</table>
| **Promote Effective Communication & Coordination of Care** | ● Medication Management  
● Admissions and Readmissions to Hospitals  
● Transfer of Health Information and Interoperability |
| **Promote Effective Prevention & Treatment of Chronic Disease** | ● 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 |
| **Make Care Affordable** | ● Appropriate Use of Healthcare  
● Patient-focused Episode of Care  
● Risk Adjusted Total Cost of Care |
| **Make Care Safer by Reducing Harm Caused in the Delivery of Care** | ● Healthcare-associated Infections  
● Preventable Healthcare Harm |
| **Strengthen Person & Family Engagement as Partners in their Care** | ● Care is Personalized and Aligned with Patient’s Goals  
● End of Life Care according to Preferences  
● Patient’s Experience of Care  
● Patient Functional Status |
| **Work with Communities to Promote Best Practices of Healthy Living** | ● Equity of Care  
● Community Engagement |
Meaningful Measures

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

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 and Functional Outcomes

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

Meaningful Measures

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

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

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

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
Meaningful Measures focus everyone’s efforts on the same quality areas and lend specificity, which can help identify measures that:

- Address high-impact measure areas that safeguard public health
- Are patient-centered and meaningful to patients, clinicians and providers
- Are outcome-based where possible
- Fulfill requirements in programs’ statutes
- Minimize level of burden for providers
- Identify significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs and/or with other payers
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
Meaningful Measures

- **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
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  Meaningful Measure Areas:
  - Equity of Care
  - Community Engagement

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  Meaningful Measure Areas:
  - Appropriate Use of Healthcare
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  - Risk Adjusted Total Cost of Care

- **Make Care Safer by Reducing Harm Caused in the Delivery of Care**
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  - Preventable Healthcare Harm

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  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
Strengthen Person & Family Engagement as Partners in their Care (1 of 2)

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

Meaningful Measure Areas

Descriptions

"An alternative approach to better care focuses on [patient goals]...researchers have been using goal-attainment scaling for decades to measure the effect of treatment for conditions such as dementia and for comprehensive geriatric assessments. Ensure the care delivered is in concert with individuals' goals, aligned with the care plan co-created with their doctor and evidenced by people making informed decisions about their care.

Fewer than 50% of even severely or terminally ill patients have an advance directive in their medical record. Ensure that care delivered at the end of life is in concert with patient/family preferences, which includes knowing those desires and providing aligned care and services.

Recent average positive reports of healthcare experiences showed variation across a range of factors, for example, from 52% for 'Care transitions' to 87% for 'Discharge information.' Actively engage patients in reporting their experiences including satisfaction with care and staff, and community inclusion.

With total knee replacement among the top five most frequent inpatient procedures, more than 50% of inpatients are being discharged home. Improve or maintain patients' quality of life by addressing physical functioning that affects their ability to undertake daily activities most important to them.
Strengthen Person & Family Engagement as Partners in their Care (2 of 2)

- 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

**Meaningful Measure Areas**

- Programs Using Illustrative Measures
  - Quality Payment Program (QPP)
  - Hospice Quality Reporting Program (HQRDP)
  - End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
  - Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
  - Skilled Nursing Facility Quality Reporting Program (SNF QRP)
  - Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
  - Medicaid and CHIP (Medicaid & CHIP)
  - Home Health Quality Reporting Program (HH QRP)

**Measures**

- Care plan
  - QPP
- Hospice Visits while Death is Imminent
  - HQRDP
- CAHPS® Hospice Survey: Getting Emotional and Religious Support
  - HQRDP
- CAHPS In-Center Hemodialysis Survey
  - ESRD QIP
- Home and Community Based Services CAHPS
  - Medicaid & CHIP
- Functional Status Assessment for Total Hip Replacement
  - QPP

**Person- and Family-Centered Care**

- Improve CMS Customer Experience
  - Support Interchangeability and Shared Decision-Making Approaches
  - Enhance Patient and Family Engagement
- Enhance Access to Care Services
  - Reduce Barriers
  - Increase Awareness
- Achieve Health Equity
  - Reduce Inequity
  - Increase Access

**Back to Outcomes & Outcomes**

**CMS**

**Centers for Medicare & Medicaid Services**
Promote Effective Communication & Coordination of Care (1 of 2)

### Medication Management

**Descriptions**

Annual health care costs in the U.S. from Adverse Drug Events (ADEs) are estimated at $3.5 billion, resulting in 7,000 deaths annually. Avoid medication errors, drug interactions, and negative side effects by reconciling and tailoring prescriptions to meet the patient’s care needs.

### Admissions and Readmissions to Hospitals

Nearly 1 in 5 Medicare fee-for-service hospital discharges have previously resulted in a readmission within 30 days, accounting for more than $17 billion in avoidable Medicare expenditures. Prevent unplanned admissions and readmissions to the hospital; unplanned admissions and readmissions have negative impacts on patients, caregivers, and clinical resources, and can be prevented with effective care coordination and communication.

### Transfer of Health Information and Interoperability

Fewer than 10% of physicians have fully functional electronic medical record/electronic health record (EMR/EHR) systems. Promote interoperability to ensure current and useful information follows the patient and is available across every setting and at each healthcare interaction.
Promote Effective Communication & Coordination of Care (2 of 2)

Effective Communication and Care Coordination

Medication Management

Admissions and Readmissions to Hospitals

Transfer of Health Information and Interoperability

Meaningful Measure Areas

Programs Using Illustrative Measures
- Quality Payment Program (QPP)
- Medicare Shared Savings Program (MSSP)
- Health Insurance Marketplace Quality Rating System (QRS)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

Measures
- Use of High Risk Medications in the Elderly (QPP)
- Medication Reconciliation Post-Discharge (MSSP)
- Annual Monitoring for Patients on Persistent Medications (MPM) (QRS)
- Drug Regimen Review Conducted with Follow-Up for Identified Issues (IRF QRP, LTCH QRP, SNF QRP, HH QRP)
- Standardized Readmission Ratio (SRR) (ESRD QIP)
- Plan All-Cause Readmissions (Medicaid & CHIP)
- Use of an Electronic Health Record (IPFQR, QIO)

Home Health Quality Reporting Program (HH QRP)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Medicaid and CHIP (Medicaid & CHIP)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Quality Improvement Organization (QIO)
Promote Effective Prevention & Treatment of Chronic Disease (1 of 2)

Descriptions

Many screening rates, like those for breast (72%), cervical (83%), and colorectal (59%) cancers are below desired levels and reflect disparities across ethnicity/race. Prevent diseases by providing immunizations and evidence-based screenings, and merit healthy lifestyle behaviors and addressing maternal and child health.

People with multiple chronic conditions account for 93% of total Medicare spending. Promote effective management of chronic conditions, particularly for those with multiple chronic conditions.

Annually, 1 in 5 or 43.8 million adults in the U.S. experience mental illness. Diagnosis, prevention and treatment of depression and effective management of mental disorders (e.g., schizophrenia, bipolar disorder), and dementia (e.g., Alzheimer’s disease) with emphasis on effective integration with primary care.

Annually, 3 out of 5 drug overdose deaths involve an opioid, resulting in over $72 billion in medical costs. Ensure screening for and treatment of substance use disorders, including those co-occurring with mental health disorders.

Heart disease, cancer, and chronic lower respiratory diseases are among the leading causes for death. Reduce mortality rate for patients in all healthcare settings.
Promote Effective Prevention & Treatment of Chronic Disease (2 of 2)

Prevention and Treatment of Chronic Disease

Programs Using Illustrative Measures
- Quality Payment Program (QPP)
- Home Health Quality Reporting Program (HH QRP)
- Medicaid and CHIP (Medicaid & CHIP)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Hospital Value-Based Purchasing (HVPB) Program

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

Measures

- Influenza Immunization Received for Current Flu Season
  - HH QRP
- Timeliness of Prenatal Care (PPC)
  - Medicaid & CHIP
- Well-Child Visits in the First 15 Months of Life (6 or More Visits)
  - Medicaid & CHIP
- Osteoporosis Management in Women Who Had a Fracture
  - QPP
- Hemoglobin A1c Test for Pediatric Patients (eCQM)
  - Medicaid & CHIP
- Follow-up after Hospitalization for Mental Illness
  - IPFQR
- Alcohol Use Screening
  - IPFQR
- Use of Opioids at High Dosage
  - Medicaid & CHIP
- Hospital 30-Day, All Cause, Risk-Standardized Mortality Rate (RSMDR) Following Heart Failure (HF) Hospitalization
  - HVBP
Promote Effective Prevention & Treatment of Chronic Disease – Example

Prevention and Treatment of Opioid and Substance Use Disorders

Meaningful Measure Areas

- Alcohol Use Screening
  - Inpatient Psychiatric Facility Quality Reporting Program
- Use of Opioids at High Dosage
  - Medicaid & CHIP
Where to Find Meaningful Measures

CMS Measures Inventory Tool: https://www.cms.cmit.gov
Go to:

Give us your feedback!
MeaningfulMeasuresQA@cms.hhs.gov
Question: Which of the Areas are most critical to you, and why?

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- Patient Functional Status
Patients Over Paperwork - CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients and consumers.
Thank you!

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