November 2016 Issue

Centers for Medicare & Medicaid Services November 2016 [Edition 10, Volume 1]

Welcome!

This month's newsletter discusses the purpose and benefits of the Quality Payment Program. We also highlight Business Cases and why they are needed in the measure management process.

Every edition includes a link to the latest CMS Blueprint as well as a calendar of upcoming opportunities and events.

We hope you find this newsletter useful and we welcome any feedback or suggestions to make it even better.

Contents

Please send comments or suggestions for future newsletters to MMSSupport@battelle.org.

Measures Management & You

Quality Payment Program

On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program improves Medicare by helping clinicians focus on care quality and the one thing that matters most — making patients healthier. MACRA ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years.

The Quality Payment Program's purpose is to provide new tools and resources to help clinicians give patients the best possible, highest-value care. The Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system. Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

The Quality Payment Program has two tracks to choose from: Advanced Alternative Payment Models (APMs) and Merit-based Incentive Payment System (MIPS). If a clinician decides to take part in an Advanced APM, they may earn a Medicare incentive payment for participating in an innovative payment model. If a clinician decides to participate in traditional Medicare, they may earn a performance-based payment adjustment through MIPS.

The Quality Payment Program is focused on moving the payment system to reward high-value, patient centered care. To be successful in the long run, the Quality Payment Program must account for diversity

in care delivery, giving clinicians options that work for them and their patients. CMS expects the Quality Payment Program to evolve over multiple years and therefore, finalizes the rule with an additional 60-day comment period to continue to solicit input from clinicians, patients, and others.

For additional information about the Quality Payment Program and how to comment go to the new Quality Payment Program website. https://qpp.cms.gov/

There is a call on Tuesday, November 15, 2016 from 1:30pm—3:00pm EST on the Quality Payment Program Final Rule. Go to this website for additional information: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2016-11-15-QPP.html

The target audience for this call includes Medicare Part B Fee-For-Service clinicians, office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

Measures Management Up Close

Each month, we will bring you an introspective look at a measures management topic.

Building an Effective Business Case: All Benefits Matter

Preparing and submitting a business case is an important, but often overlooked, part of measure development. The business case provides information needed to assess the anticipated benefits of a quality measure against the resources and costs required to implement that measure. CMS reviews the business case to determine whether there is sufficient reason to dedicate resources and move that measure forward in the measure development process.

While a business case is required for all measures, *not all measures are required to demonstrate cost savings.* Rather, the business case in an opportunity for the measure developer to demonstrate that the benefits of a measure outweigh the costs. Different business case models may highlight benefits in addition to or in lieu of cost savings. For instance, a measure intended to demonstrate improved care coordination *may* show reduced expenses associated with unnecessary readmissions, but it may focus more on reduced mortality in selected populations and improvement patient satisfaction.

All the anticipated benefits of a measure, including, but not limited to financial outcomes should be presented. Benefits may include:

Better care through improvement in the quality of care provided and positive influence on patients' perception of their care.

Better health through reduction in mortality and morbidity, and improvements in quality of life.

More affordable care through cost savings.

Given that the business case is used to document why it is worthwhile for CMS to invest resources to support the measure, it is important that it is updated throughout the measure lifecycle. The business case starts early during measure conceptualization, is enhanced throughout measure development, and should be used to compare actual results during measure reevaluation and maintenance.

For additional information on preparing and submitting the business case, including best practices, please refer to Section 3, Chapter 8 of the latest version of the MMS Blueprint.

Upcoming Events

The Joint Commission: Pioneers in Quality Expert to Expert Series - ePC 1 & 5 on November 8, 2016, 12 PM ET

- Register for the event here

IPFQR Program FY 2019 New Measures Review on November 14, 2016 at 2 PM ET

- Register for the event here

Quality Payment Program Final Rule Call on November 15, 2016 at 1:30-3:00 PM ET

- Register for the event here

IRF and LTCH Quality Measure Report Call on December 1, 2016 at 1:30-3:00 PM ET

- Register for the event here

Upcoming Opportunities

Opportunities for Public Comment on quality measures

Development of Functional Outcome Quality Measures for Skilled Nursing Facilities (SNFs)

- Public comment period opened October 7, 2016, and will close on November 4, 2016.

MACRA Episode-Based Cost Measures Technical Expert Panel

- Public comment period opened October 26, 2016, and will close on November 16, 2016.

Refinement of Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) and Language Modifications Being Explored with the Term "Pressure Injury"

- Public comment period opened October 12, 2016, and will close on November 17, 2016.

Please check the CMS Quality Measures Public Comment Web Page for current Public Comment announcements and summary reports.

Opportunities to participate in a Technical Expert Panel (TEP)

Please check the CMS Quality Measures Call for TEP Web Page for current TEP membership lists and meeting summaries.

New to the listserv or miss a month? Find all of our announcements here.

Please send comments and suggestions to MMSSupport@battelle.org.