The Physician’s Role in Delivery System Reform

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Director, Center for Medicare and Medicaid innovation

Director, Center for Clinical Standards and Quality

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In three words, our vision for improving health delivery is about **better, smarter, healthier.**

If we find better ways to **deliver care, pay providers, and distribute information**, we can receive better care, spend our dollars more wisely, and have healthier communities, a healthier economy, and a healthier country.

We understand that it’s **our role and responsibility to lead … and we will.**

What we won’t do – and can’t do – is go it alone. Patients, providers, government, and business all stand to benefit if we get this right, and this **shared purpose calls out for deeper partnership.**

So we will continue to work across sectors for the goals we share: **better care, smarter spending, and healthier people.**
Overview

Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Quality Measurement
CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people.

<table>
<thead>
<tr>
<th>Historical state</th>
<th>Evolving future state</th>
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<tbody>
<tr>
<td><strong>Key characteristics</strong></td>
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<tr>
<td>- Producer-centered</td>
<td>- Patient-centered</td>
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<td>- Incentives for volume</td>
<td>- Incentives for outcomes</td>
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<td>- Unsustainable</td>
<td>- Sustainable</td>
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<td>- Fragmented Care</td>
<td>- Coordinated care</td>
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<td><strong>Systems and Policies</strong></td>
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<td>- Fee-For-Service Payment Systems</td>
<td>- Value-based purchasing</td>
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<td>- Accountable Care Organizations</td>
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<td>- Bundled payments</td>
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<td>- Medical Homes</td>
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<td>- Quality/cost transparency</td>
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<td>- Population-based payments</td>
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Public and private sectors
Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information.

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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<tbody>
<tr>
<td>Pay Providers</td>
<td>▪ Promote value-based payment systems</td>
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<td></td>
<td>– Test alternative payment models</td>
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<td>– Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
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<td>▪ Bring proven alternative payment models to scale</td>
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<td>Deliver Care</td>
<td>▪ Encourage the integration and coordination of clinical and support services</td>
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<td>▪ Improve population health</td>
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<td>▪ Promote patient engagement through shared decision making</td>
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<td>Distribute Information</td>
<td>▪ Create transparency on cost and quality information</td>
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<td></td>
<td>▪ Bring electronic health information to the point of care for meaningful use</td>
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Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
CMS has adopted a framework that categorizes payments to providers

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
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<tr>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
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<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
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<tr>
<td>Readmissions / Hospital Acquired Condition Reduction Program</td>
<td>Accountable Care Organizations</td>
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<td></td>
<td>Medical homes</td>
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<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
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<td>Bundled payments</td>
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<td>Maryland hospitals</td>
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<td>Comprehensive Primary Care initiative</td>
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<td>Comprehensive ESRD</td>
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<td></td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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During January 2015, HHS announced goals for value-based payments within the Medicare FFS system:

- **30%** of 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.

- **85%** of all Medicare fee-for-service payments are tied to quality or value (*categories 2-4*) by the end of 2016, and **90%** by the end of 2018.

**Purpose**

- Set *internal goals* for HHS.
- Invite *private sector payers and Medicaid* to match or exceed HHS goals.

**Stakeholders**

- Consumers
- Businesses/Purchasers
- Payers
- Providers
- State partners (including Medicaid programs)

**Next steps**

- Testing of new models and expansion of existing models is critical to reaching incentive goals.
- Creation of the Health Care Payment *Learning and Action Network* to align incentives and identify best practices.
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

Historical Performance:
- 2011: 0% (Alternative), 68% (FFS), 32% (All)
- 2014: ~20% (Alternative), >80% (FFS), 80% (All)
- 2016: 30% (Alternative), 85% (FFS), 75% (All)
- 2018: 50% (Alternative), 90% (FFS), 80% (All)

Goals:
- 2011: 0% (Alternative), 68% (FFS), 32% (All)
- 2014: ~20% (Alternative), >80% (FFS), 80% (All)
- 2016: 30% (Alternative), 85% (FFS), 75% (All)
- 2018: 50% (Alternative), 90% (FFS), 80% (All)
CMS is aligning with private sector and states to drive delivery system reform

CMS Strategies for Aligning with Private Sector and States

Convening Stakeholders
- Convened payers in 7 markets in Comprehensive Primary Care
- Convening payers, providers, employers, consumers, and public partners through the Health Care Payment Learning and Action Network

Incentivizing Providers
- Pioneer ACOs agreements required 50% of the ACO’s business to be in value-based contracts by the end of the second program year

Partnering with States
- The State Innovation Models Initiative funds testing awards and model design awards for states implementing comprehensive delivery system reform
- The Maryland All-Payer Model tests the effectiveness of an all-payer rate system for hospital payments
Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Quality Measurement
Results: Per Capita Spending Growth at Historic Lows

Source: CMS Office of the Actuary

*Medicare Part D prescription drug benefit implementation, Jan 2006
Pioneer ACOs provided higher quality and lower cost care to Medicare beneficiaries in their first two performance years

- Pioneer ACOS were designed for organizations with experience in coordinated care and ACO-like contracts

- Pioneer ACOs showed improved quality outcomes
  - Quality outperformed published benchmarks in 15/15 clinical quality measures and 4/4 patient experience measures in year 1 and improved in year 2
  - Mean quality score of 85.2% in 2013 compared to 71.8% in 2012
  - Average performance score improved in 28 of 33 (85%) quality measures

- Pioneer ACOs generated savings for 2nd year in a row
  - $384M in program savings combined for two years†
  - Average savings per ACO increased from $2.7 million in PY1 to $4.2 million in PY2‡

- 19 ACOs operating in 12 states (AZ, CA, IA, IL, MA, ME, MI, MN, NH, NY, VT, WI) reaching over 600,000 Medicare fee-for-service beneficiaries

- Duration of model test: January 2012 – December 2014; 19 ACOs extended for 2 additional years

† Results from regression based analysis
‡ Results from actuarial analysis
Comprehensive Primary Care (CPC) is showing early positive results

- CMS convenes Medicaid and commercial payers to support primary care practice transformation through enhanced, non-visit-based payments, data feedback, and learning systems.

- Across all 7 regions, CPC reduced Medicare Part A and B expenditures per beneficiary by $14 or 2%*.
  - Reductions appear to be driven by initiative-wide impacts on hospitalizations, ED visits, and unplanned 30-day readmissions.

- 7 regions (AR, OR, NJ, CO, OK, OH/KY, NY) encompassing 31 payers, nearly 500 practices, and approximately 2.5 million multi-payer patients.

* Reductions relative to a matched comparison group and do not include the care management fees (~$20 pbpm)
SAMA Healthcare Services is an independent four-physician family practice located in El Dorado, a town in rural southeast Arkansas.

**Services made possible by CPC investment**

- **Care management**
  - Each **Care Team** consists of a doctor, a nurse practitioner, a care coordinator, and three nurses.
  - Teams drive **proactive preventive care** for approximately 19,000 patients.
  - Teams use Allscripts’ **Clinical Decision Support** feature to alert the team to missing screenings and lab work.

- **Risk stratification**
  - The practice implemented the **AAFP six-level risk stratification tool**.
  - Nurses mark records **before the visit** and physicians **confirm stratification during the patient encounter**.

- **Practice Administrator**
  
  “A lot of the things we’re doing now are things we wanted to do in the past... We needed the front-end investment of start-up money to develop our teams and our processes.”
Partnership for Patients contributes to quality improvements and cost savings

- Data shows a 17% reduction in hospital acquired conditions across all measures from 2010 – 2013
  - 50,000 lives saved
  - 1.3 million patient harm events avoided
  - $12 billion in savings

- Many areas of harm dropping dramatically – patient safety improving

### Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th></th>
<th>Ventilator-Associated Pneumonia</th>
<th>Early Elective Delivery</th>
<th>Central Line-Associated Blood Stream Infections</th>
<th>Venous thromboembolic complications</th>
<th>Re-admissions</th>
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<tr>
<td></td>
<td>62.4% ↓</td>
<td>70.4% ↓</td>
<td>12.3% ↓</td>
<td>14.2% ↓</td>
<td>7.3% ↓</td>
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Delivery System Reform and Our Goals

Early Results

CMS Innovation Center
The Innovation Center portfolio aligns with delivery system reform focus areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CMS Innovation Center Portfolio*</th>
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<tbody>
<tr>
<td>Pay Providers</td>
<td>Test and expand alternative payment models</td>
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<td>- Accountable Care</td>
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<td>- Pioneer ACO Model</td>
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<td>- Medicare Shared Savings Program (housed in Center for Medicare)</td>
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<td>- Advance Payment ACO Model</td>
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<td>- Comprehensive ERSD Care Initiative</td>
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<td>- Primary Care Transformation</td>
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<td>- Comprehensive Primary Care Initiative (CPC)</td>
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<td>- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<td>- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
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<td>- Independence at Home Demonstration</td>
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<td>- Graduate Nurse Education Demonstration</td>
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<td>- Bundled Payment for Care Improvement</td>
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<td>- Model 1: Retrospective Acute Care</td>
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<td>- Model 2: Retrospective Acute Care Episode &amp; Post Acute</td>
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<td>- Model 3: Retrospective Post Acute Care</td>
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<td>- Model 4: Prospective Acute Care</td>
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<td>- Oncology Care Model</td>
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<td>- Initiatives Focused on the Medicaid</td>
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<td>- Medicaid Emergency Psychiatric Demonstration</td>
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<td>- Medicaid Incentives for Prevention of Chronic Diseases</td>
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<td>- Strong Start Initiative</td>
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<td>- Medicaid Innovation Accelerator Program</td>
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<td>- Dual Eligible (Medicare-Medicaid Enrollees)</td>
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<td>- Financial Alignment Initiative</td>
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<td>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<tr>
<td>Deliver Care</td>
<td>Support providers and states to improve the delivery of care</td>
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<td>- Learning and Diffusion</td>
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<td>- Partnership for Patients</td>
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<td>- Transforming Clinical Practice</td>
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<td>- Community-Based Care Transitions</td>
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<td>- Health Care Innovation Awards</td>
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<td>- State Innovation Models Initiative</td>
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<td>- SIM Round 1</td>
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<td>- SIM Round 2</td>
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<td>- Maryland All-Payer Model</td>
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<tr>
<td>Distribute Information</td>
<td>Increase information available for effective informed decision-making by consumers and providers</td>
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<td></td>
<td>- Information to providers in CMMI models</td>
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<td>- Shared decision-making required by many models</td>
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* Many CMMI programs test innovations across multiple focus areas
Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- 424 ACOs have been established in the MSSP and Pioneer ACO programs
- 7.8 million assigned beneficiaries
- This includes 89 new ACOs covering 1.6 million beneficiaries assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County
The bundled payment model targets 48 conditions with a single payment for an episode of care

- Incentivizes providers to take accountability for both cost and quality of care
- Four Models
  - Model 1: Retrospective acute care hospital stay only
  - Model 2: Retrospective acute care hospital stay plus post-acute care
  - Model 3: Retrospective post-acute care only
  - Model 4: Acute care hospital stay only

102 Awardees and 167 episode initiators in phase 2 as of January 2015
85 new awardees and 373 new episode initiators will enter phase 2 in April 2015

Duration of model is scheduled for 3 years:
- Model 1: April 2013 to present
- Models 2,3,4: October 2013 to present

* Current as of January 2015
CMS is testing the ability of state governments to utilize policy and regulatory levers to accelerate health care transformation.

Primary objectives include:
- Improving the quality of care delivered
- Improving population health
- Increasing cost efficiency and expand value-based payment

State Innovation Model grants have been awarded in two rounds:
- Six round 1 model test states
- Eleven round 2 model test states
- Twenty one round 2 model design states
Round 1 states are testing and Round 2 states are designing and implementing comprehensive reform plans

### Round 1 States testing APMs

<table>
<thead>
<tr>
<th>Patient centered medical homes</th>
<th>Accountable care</th>
<th>Episodes</th>
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<tbody>
<tr>
<td>Arkansas</td>
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<td>Maine</td>
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<td>Massachusetts</td>
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<td>Minnesota</td>
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<td>Oregon</td>
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<td>Vermont</td>
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### Round 2 States designing interventions

- **Near term CMMI objectives**
  - Establish project milestones and success metrics
  - Support development of states’ stakeholder engagement plans
  - Onboard states to Technical Assistance Solution Center and SIMergy Collaboration site
  - Launch State HIT Resource Center and CDC support for Population Health Plans
Maryland is testing an innovative All-Payer Payment Model

- Maryland is the nation’s only all-payer hospital rate regulation system

- Model will test whether effective accountability for both cost and quality can be achieved within all-payer system based upon **per capita total hospital cost growth**

- **Quality of care** will be measured through
  - Readmissions
  - Hospital Acquired Conditions
  - Population Health

- Maryland has ~6 million residents*
- Hospitals began moving into All-Payer Global Budgets in July 2014
  - 95% of Maryland hospital revenue will be in global budgets
  - All 46 MD hospitals have signed agreements
- Model was initiated in January 2014; Five year test period

* US census bureau estimate for 2013
Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation

- The model will support over **150,000 clinician practices** over the next four years to **improve on quality, lower costs, and enter alternative payment models**
- Two network systems will be created

1) **Practice Transformation Networks**: peer-based learning networks designed to coach, mentor, and assist

2) **Support and Alignment Networks**: provides a system for utilizing professional associations and public-private partnerships to drive improvement
We are focused on:

- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio
Next Generation ACO Model

• A new opportunity in accountable care:
  – More predictable financial targets;
  – Greater opportunities to coordinate care;
  – High quality standards consistent with other Medicare programs and models.

• The Model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Original Medicare beneficiaries.
Model Principles

- Protect Medicare FFS beneficiaries’ freedom of choice;
- Create a financial model with long-term sustainability;
- Use a prospectively-set benchmark that:
  - Rewards quality;
  - Rewards both attainment of and improvement in efficiency; and
  - Ultimately transitions away from updating benchmarks based on ACO’s recent expenditures;
- Offer benefit enhancements that directly improve the patient experience and support coordinated care (e.g., telehealth);
- Allow beneficiaries a choice in their alignment with the ACO
  - Mitigates fluctuations in aligned beneficiary populations
  - Respects beneficiary preferences;
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms (e.g. population-based payments).
Delivery System Reform and Our Goals

Early Results

CMS Innovation Center

Quality Measurement
Landscape of Quality Measurement

HISTORIC

• Siloed approach to quality measurement

• No clear measure development strategy

• Process Measures with little performance variation

• Confusing and Burdensome to stakeholders

• Lack of patient voice

VISION

• Align measures with the National Quality Strategy

• Develop measures meaningful to patients and providers

• Focus on outcomes, safety, patient experience, care coordination, appropriate use, and cost

• Prioritize “cross-cutting” measures that are applicable to populations

• Align measures across CMS programs

• Expand EHR and Registry-based reporting

• Removal of measures that are no longer appropriate
Focusing on Outcomes

Focusing on the end results of care and not the technical approaches that providers use to achieve the results

Measure 30 day mortality rates, hospital-acquired infections, etc...

Allows for local innovations to achieve high performance on outcomes
Challenges in Measuring Performance

Determining indicators of outcomes that reflect national priorities

Recognizing that outcomes are usually influenced by multiple factors

Determining thresholds for ‘good’ performance

Recognizing that Process Measures don’t always predict outcomes
Principles for Measure Development in the Future Payment Environment

• Measures should explicitly align with the CMS Quality Strategy and its goals and objectives.

• Measures should address a performance gap where there is known variation in performance, not just a measure gap.

• Patient/caregiver input is at least equally important to provider input in the development of measures.

• Focus on electronic data sources – directly from EHR and/or via registry
Principles for Measure Development (cont’d)

• Reorient and align measures around patient-centered outcomes that span across settings

• Develop measures meaningful to patients/caregivers and providers, focused on outcomes, safety, patient experience, care coordination, appropriate use, and cost.

• Monitor disparities and unintended consequences.
Critical Challenges in Measure Development

• Defining the right outcome/performance gap

• Engaging patients in the measure development process

• Advancing the science for critical measure types: PROMs, resource use, appropriate use, etc.

• Robust feasibility, reliability and validity testing

• Developing measures that reflect and assess shared accountability across settings and providers

• Reduction of provider burden and cost to reporting measures

• Length of time it takes to develop measures
Phillips RL et al: MOC, Medicare Quality Reporting, and Quality of Diabetes Care

• Compared change in performance on 12 CQMs for physicians who participated in PQRS and ABFM Performance Practice Modules (PPMs) vs. those who only did PPMs

• Results:
  – Each cohort improved over time
  – Greater improvement in performance on intermediate outcome measures by physicians who completed both PQRS and PPMs
  – Greater improvement in performance on process measures by physicians who completed PPMs only
• Conclusions
  – Participation in PPMs and PQRS is associated with improvement on CQMs
  – Given the demonstrated positive impact of participation in self-assessment through MOC and of participation in PQRS, it makes sense to align the two programs
  – Alignment would allow physicians to work towards the same goals for both internal improvement and value-based incentive programs
Physician Quality Reporting Programs
2015 Measure Reporting Methods

• **EHR Reporting** for group practices and individuals

• **Certified Survey Vendor Option** for purposes of reporting the CG-CAHPS measures, available to group practices that register to participate in the Group Practice Reporting Option (GPRO)

• **Qualified Clinical Data Registry (QCDR)**

• **Traditional PQRS Registry**

• **CMS Web Interface** for group practices of 10 or more

• **“G code” claims** (phasing out)
PQRS Open Call for Measures

- CMS is seeking a quality set of measures that lead to health outcomes.
- Preference will be given to outcome or intermediate outcome measures as well as measures of patient safety and adverse events, appropriate use of diagnostics and therapeutics, care coordination and communication, patient experience and patient-reported outcomes and measures of cost and resource use.
- CMS is not accepting claims-based only reporting measures in this process.
- For detailed information on the measure submission process, access the MMS website.
## Public Reporting by Year

<table>
<thead>
<tr>
<th>Targeted Date of Publication on Physician Compare Website</th>
<th>Rule</th>
<th>PQRS GPROs</th>
<th>ACOs</th>
<th>Patient Experience of Care Measures</th>
<th>Individual Eligible Professionals (EPs)</th>
</tr>
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<tbody>
<tr>
<td>Late 2016*</td>
<td>2015 Physician Fee Schedule (PFS) Final Rule</td>
<td>All 2015 PQRS GPRO measures collected via the Web Interface, Registry, and EHR</td>
<td>All 2015 measures reported by ACOs regardless of reporting mechanism</td>
<td>2015 CAHPS for PQRS and CAHPS for ACOs</td>
<td>All 2015 PQRS measures collected via an EHR, Registry, or Claims 2015 QCDR measures</td>
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<td></td>
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<td></td>
<td>❖ PQRS and Non-PQRS measures.</td>
<td>❖ No first year measures.</td>
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<td>❖ 2015 Individual PQRS measures in support of Million Hearts.</td>
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</table>
What can you do to help our system achieve the goals of Better Care, Smarter Spending, and Healthier People?

- Eliminate patient harm
- Focus on better care, smarter spending, and healthier people within the population you serve
- Engage in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- Invest in the quality infrastructure necessary to improve
- Focus on data and performance transparency
- Test new innovations and scale successes rapidly
- Relentlessly pursue improved health outcomes
Contact Information

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