

May CMS eHealth Vendor Workgroup

May 19, 2016
12:00 PM EDT



Agenda

Agenda Item	Speaker
Hospital Inpatient Quality Reporting (HIQR) Update	Artrina Sturges, Ed.D <i>IQR/Electronic Health Record (EHR) Alignment Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)</i>
The Merit-Based Incentive Payment System (MIPS) in the Quality Payment Program Update	Molly, MacHarris <i>Division of Electronic and Clinician Quality, Quality Measurement & Value-Based Incentives Group, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services</i>
Questions	



Hospital Inpatient Quality Reporting (IQR) Program Update

Artrina Sturges, EdD

Project Lead, IQR/Electronic Health Record (EHR) Alignment
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

May 19, 2016

2017 IPPS/LTCH Proposed Rule Published

- The Centers for Medicare & Medicaid Services (CMS) issued a Proposed Rule on April 18, 2016.
- The Proposed Rule updates fiscal year (FY) 2017 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

Commenting on the 2017 IPPS/LTCH Proposed Rule

- CMS is accepting comments on the Proposed Rule until 5 p.m. ET on **June 17, 2016**.
- Comments can be submitted four ways*:
 - Electronically
 - Regular mail
 - Express or overnight mail
 - Hand delivered or by courier
- CMS will respond to comments within the Final Rule, which is scheduled to be issued by **August 1, 2016**.

* *Please note, review the Proposed Rule for specific instructions on each method of submission and use **ONLY** one way.*

FY 2017 IPPS/LTCH Proposed Rule Page Directory

- Download the Proposed Rule from the *Federal Register* at: <http://federalregister.gov/a/2016-09120>
- Find the corresponding details for the various quality reporting programs on the following pages:
 - Hospital Readmissions Reduction Program, pp. 25094-25098
 - Hospital Value-Based Purchasing (VBP) Program, pp. 25099-25117
 - Hospital-Acquired Condition (HAC) Reduction Program, pp. 25117-25124
 - Hospital Inpatient Quality Reporting (IQR) Program, pp. 25174-25205
 - PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, pp. 25205-25213
 - Long-Term Care Hospital Quality Reporting Program (LTCH QRP), pp. 25213-25238
 - Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, pp. 25238-25244
 - Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the EHR Incentive Programs in 2017, pp. 25244-25247

2017 IPPS/LTCH Proposed Rule Webinars

- **May 9, 2016** – *FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule Short-Term Acute Care Hospital Quality Reporting Programs Overview*
- **May 17, 2016** – *FY 2017 Proposed Rule: IQR – EHR Overview*

NOTE: Details are posted on the QualityReportingCenter.com website

How to Get Involved

CMS strongly encourages vendors and hospitals to continue working toward the successful submission of eCQM data by:

- Testing QRDA Category I file structure utilizing the Pre-submission Validation Application (PSVA), current version 1.1.2
- Submitting test files through the CMS electronic Clinical Quality Measure (eCQM) Receiving System (*QualityNet Secure Portal*) once the system re-opens this year
- Signing-up for the Hospital Reporting EHR ListServe and participating in training opportunities at www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register

Resources

QualityNet Help Desk

- Qnetsupport@hcqis.org
- 1.866.288.8912, 7 a.m.–7 p.m. CT, Monday through Friday

eCQM General Program Questions

- <https://cms-ip.custhelp.com>
- 866.800.8765 or 844.472.4477, 7 a.m.–7 p.m. CT Monday through Friday

EHR (Meaningful Use) Information Center

- 888.734.6433, 7:30 a.m.–6:30 p.m., CT Monday through Friday

JIRA – Office of the National Coordinator (ONC) Project Tracking

- <http://oncprojecttracking.org> Resource to submit questions and comments regarding:
 - Issues identified with eCQM logic
 - Clarification on specifications
 - The Combined QRDA IG for 2016
 - The EHR Incentive Program

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Molly MacHarris, Program Lead MIPS, Center for Clinical Standards
and Quality



Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

KEY TOPICS:

- 1) The Quality Payment Program and HHS Secretary's Goals**
- 2) What is the Quality Payment Program?**
- 3) How do I submit comments on the proposed rule?**
- 4) The Merit-based Incentive Payment System (MIPS)**
- 5) What are the next steps?**

The Quality Payment Program 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

30% 

GOAL 2:

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

85% 



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners



Set **internal goals** for HHS



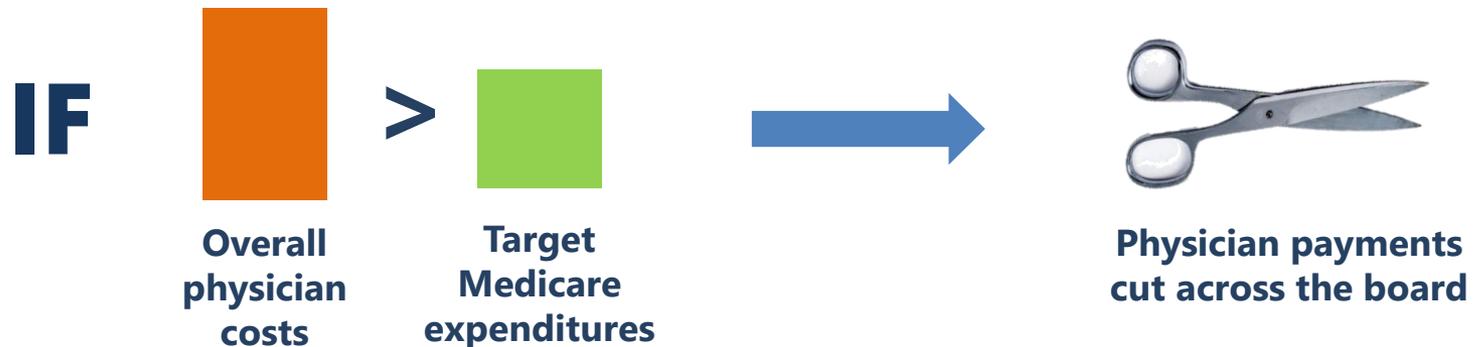
Invite **private sector payers** to match or exceed HHS goals

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians



Each year, Congress passed temporary **“doc fixes”** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value**.

The Sustainable Growth Rate (SGR)



Each year, Congress passed temporary **“doc fixes”** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

MACRA **replaces the SGR** with a **more predictable** payment method that **incentivizes value**.

INTRODUCING THE QUALITY PAYMENT PROGRAM

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



**The Merit-based
Incentive
Payment System
(MIPS)**

or

**Advanced
Alternative
Payment Models
(APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
 - Regulations.gov
 - by regular mail
 - by express or overnight mail
 - by hand or courier
- For additional information, please go to:
<http://go.cms.gov/QualityPaymentProgram>

Quality Payment Program

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**



**The Merit-based
Incentive
Payment System
(MIPS)**

or

**Advanced
Alternative
Payment Models
(APMs)**

MIPS

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
 - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
 - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**



Quality



Resource use



**Clinical practice
improvement
activities**



**Advancing care
information**

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

**Physician Quality
Reporting Program
(PQRS)**

**Value-Based Payment
Modifier (VM)**

**Medicare Electronic
Health Records (EHR)
Incentive Program**

PROPOSED RULE
MIPS: Major Provisions

- ✓ **Eligibility (participants and non-participants)**
- ✓ **Performance categories & scoring**
- ✓ **Data submission**
- ✓ **Performance period & payment adjustments**

Who Will Participate in MIPS?

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

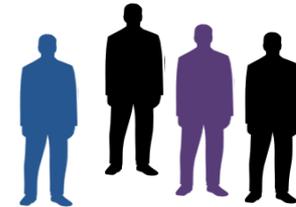
Years 1 and 2



Physicians (MD/DO and DMD/DDS),
PAs, NPs, Clinical nurse specialists,
Certified registered nurse
anesthetists

Years 3+

Secretary may
broaden Eligible
Clinicians group to
include others
such as



Physical or occupational therapists,
Speech-language pathologists,
Audiologists, Nurse midwives,
Clinical social workers, Clinical
psychologists, Dietitians /
Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare Part B participation



Below **low patient volume** threshold

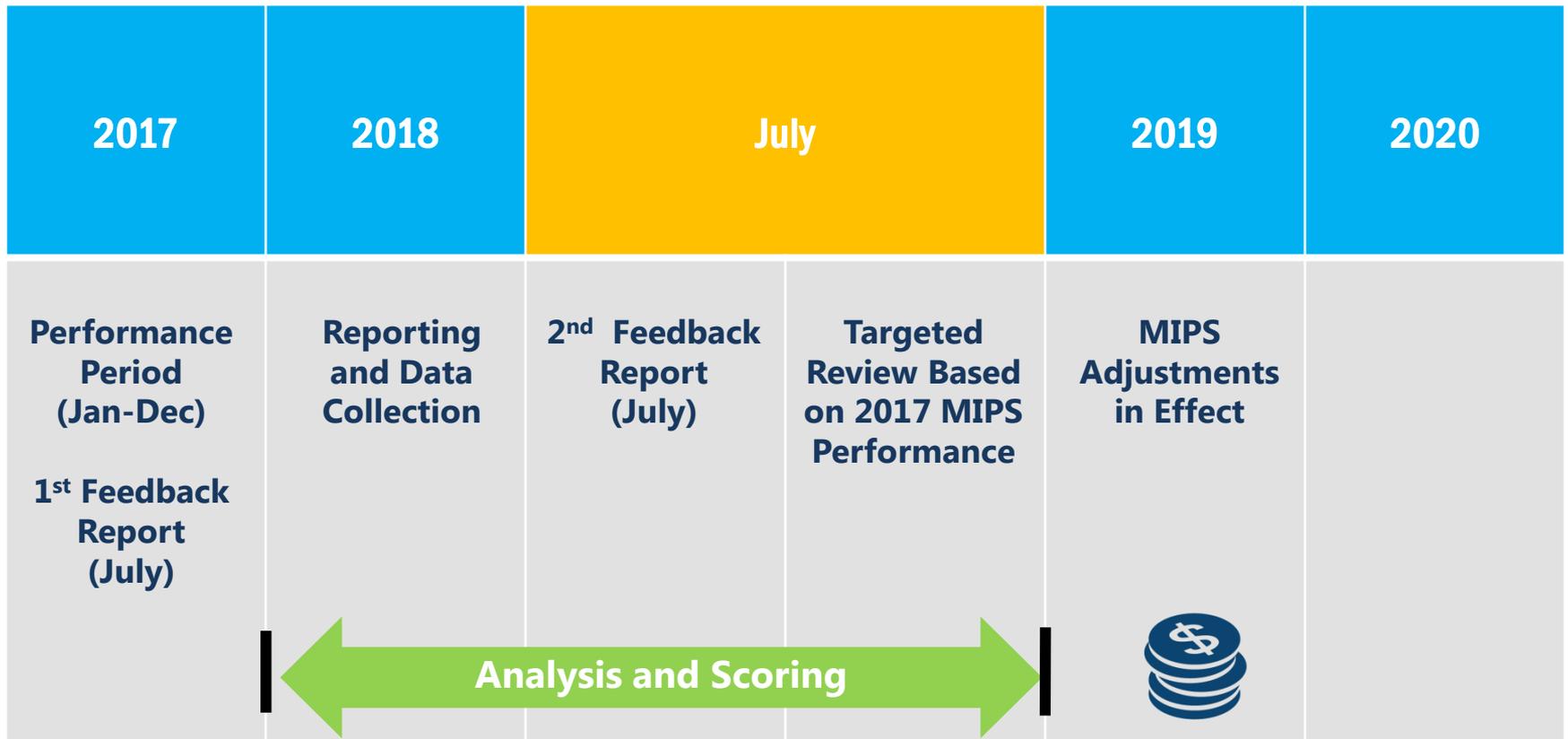


Certain participants in **ADVANCED** Alternative Payment Models

↓
Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Medicare patients in one year

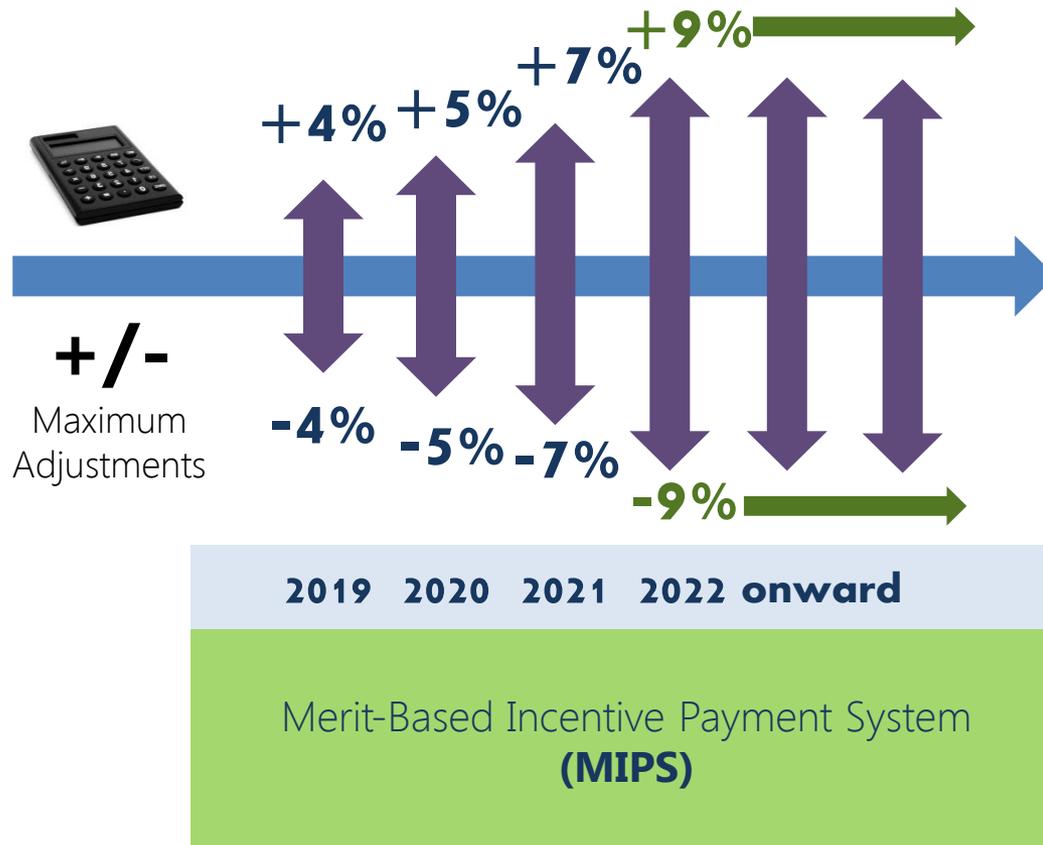
Note: MIPS **does not** apply to hospitals or facilities

PROPOSED RULE MIPS Timeline



How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.



Adjusted Medicare Part B payment to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

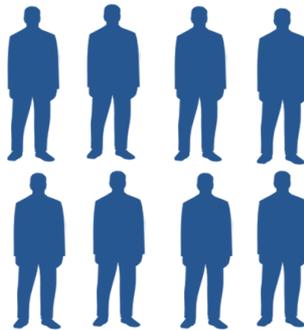
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM



In non-Advanced APM



In Advanced APM, but not a QP



QP in Advanced APM



Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

PROPOSED RULE

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:



Individual

Or



Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

PROPOSED RULE
MIPS: PERFORMANCE
CATEGORIES & SCORING

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale:**



Quality



**Resource
use**



**Clinical
practice
improvement
activities**

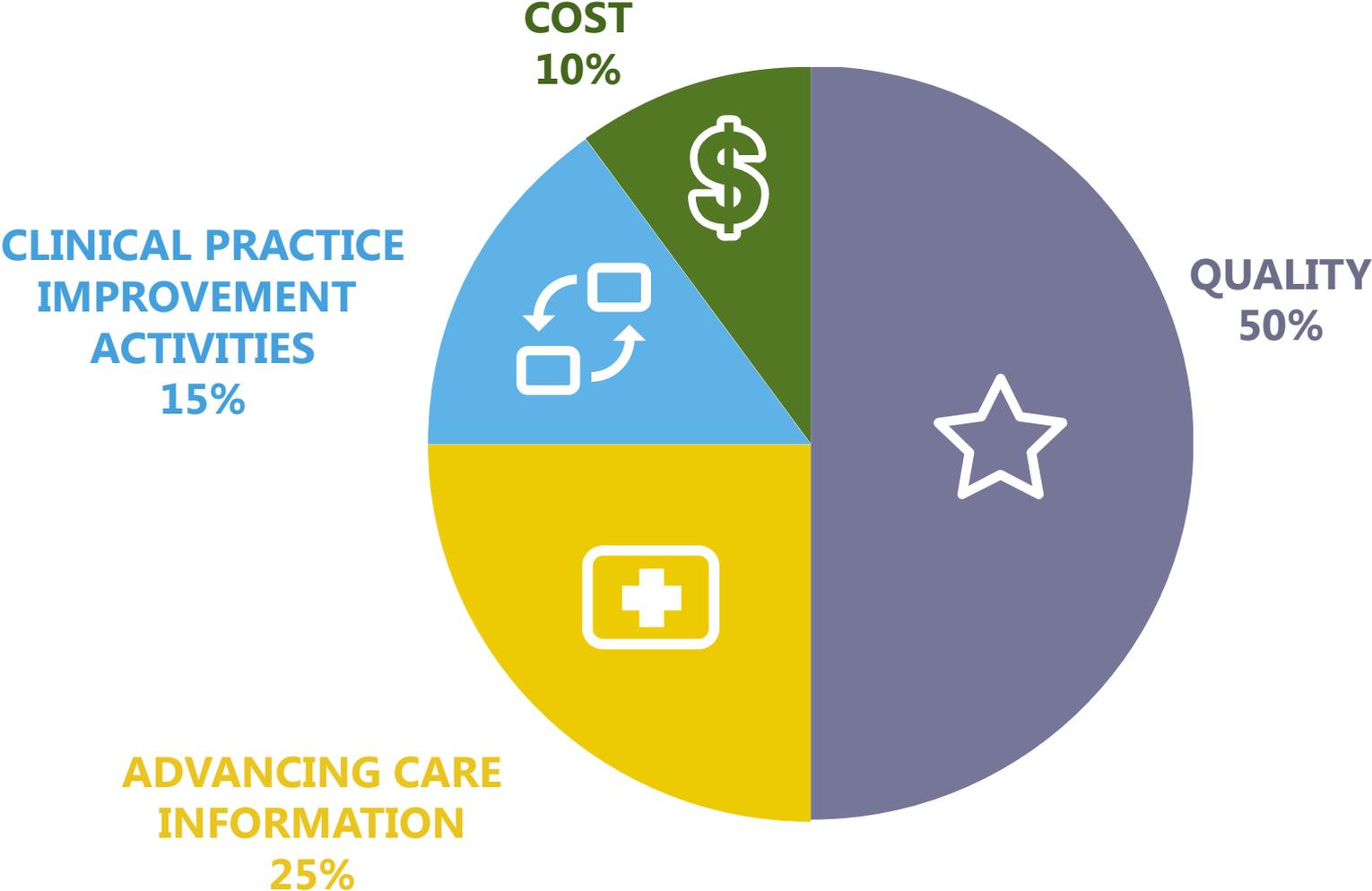


**Advancing
care
information**



**MIPS
Composite
Performance
Score (CPS)**

Year 1 Performance Category Weights for MIPS



What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



*Proposed quality measures are available in the NPRM

*clinicians will be **able to choose** the measures on which they'll be evaluated

PROPOSED RULE

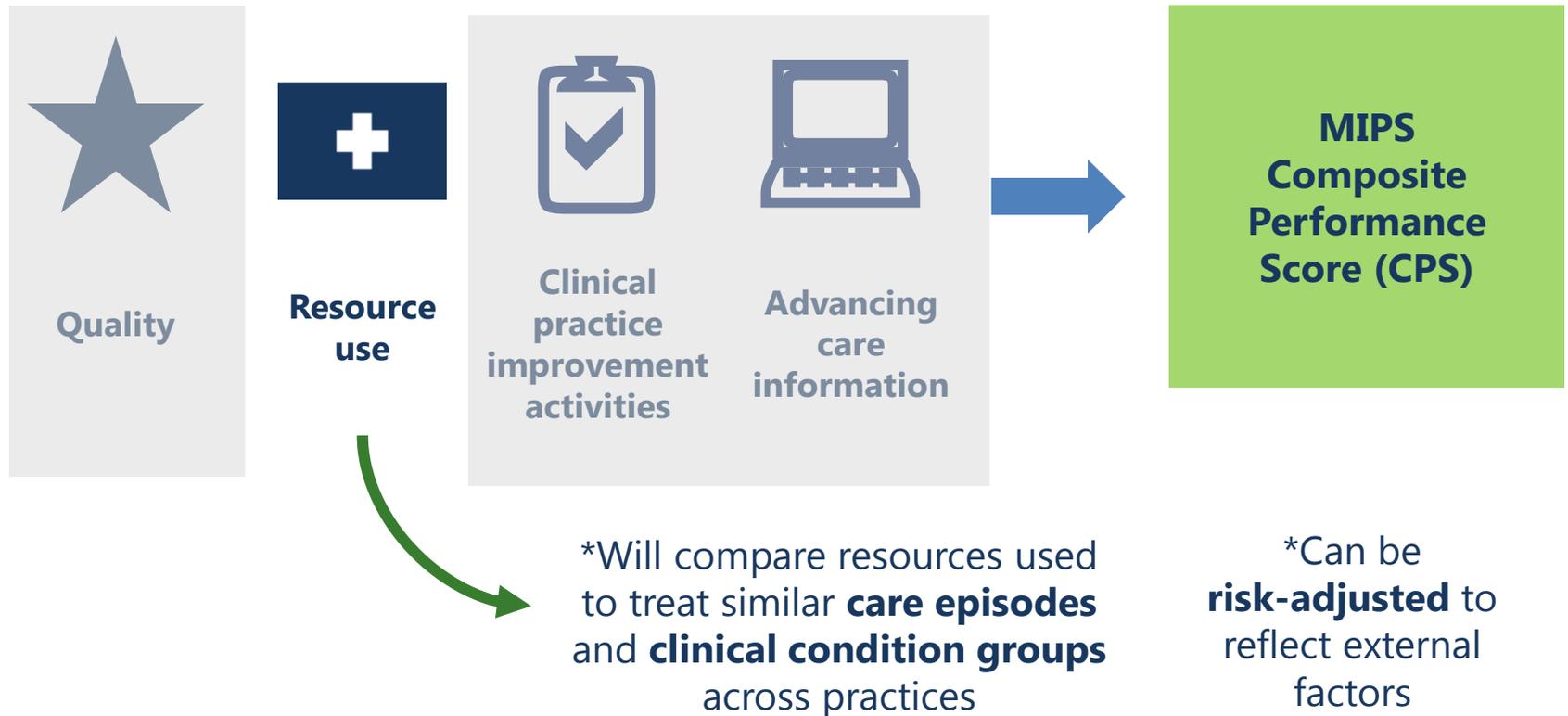
MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
 - **Reduced from 9 measures to 6 measures with no domain requirement**
 - **Emphasis on outcome measurement**
 - **Year 1 Weight: 50%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
 - **Adding 40+ episode specific measures to address specialty concerns**
 - **Year 1 Weight: 10%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



*Examples include care coordination, shared decision-making, safety checklists, expanding practice access

PROPOSED RULE

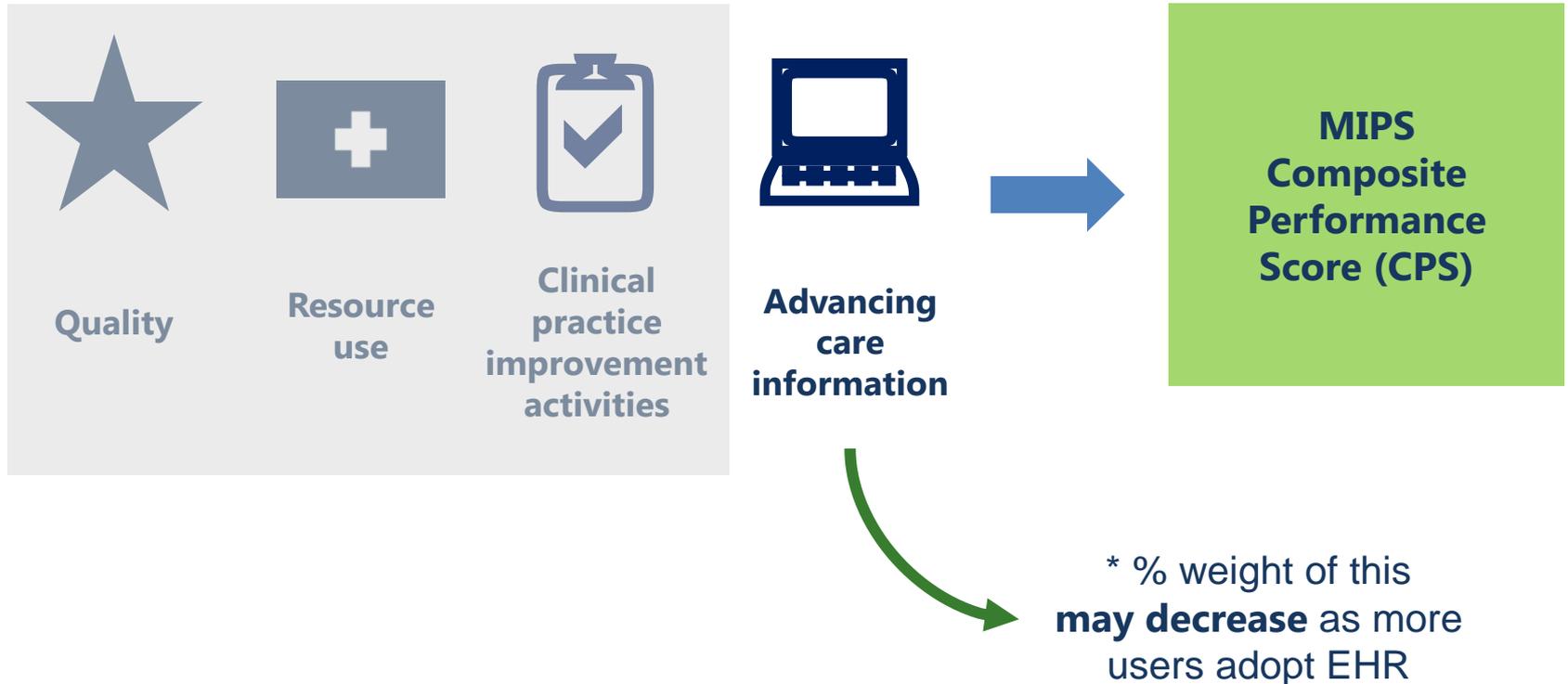
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
 - **Not applicable (new category)**
 - **Year 1 Weight: 15%**

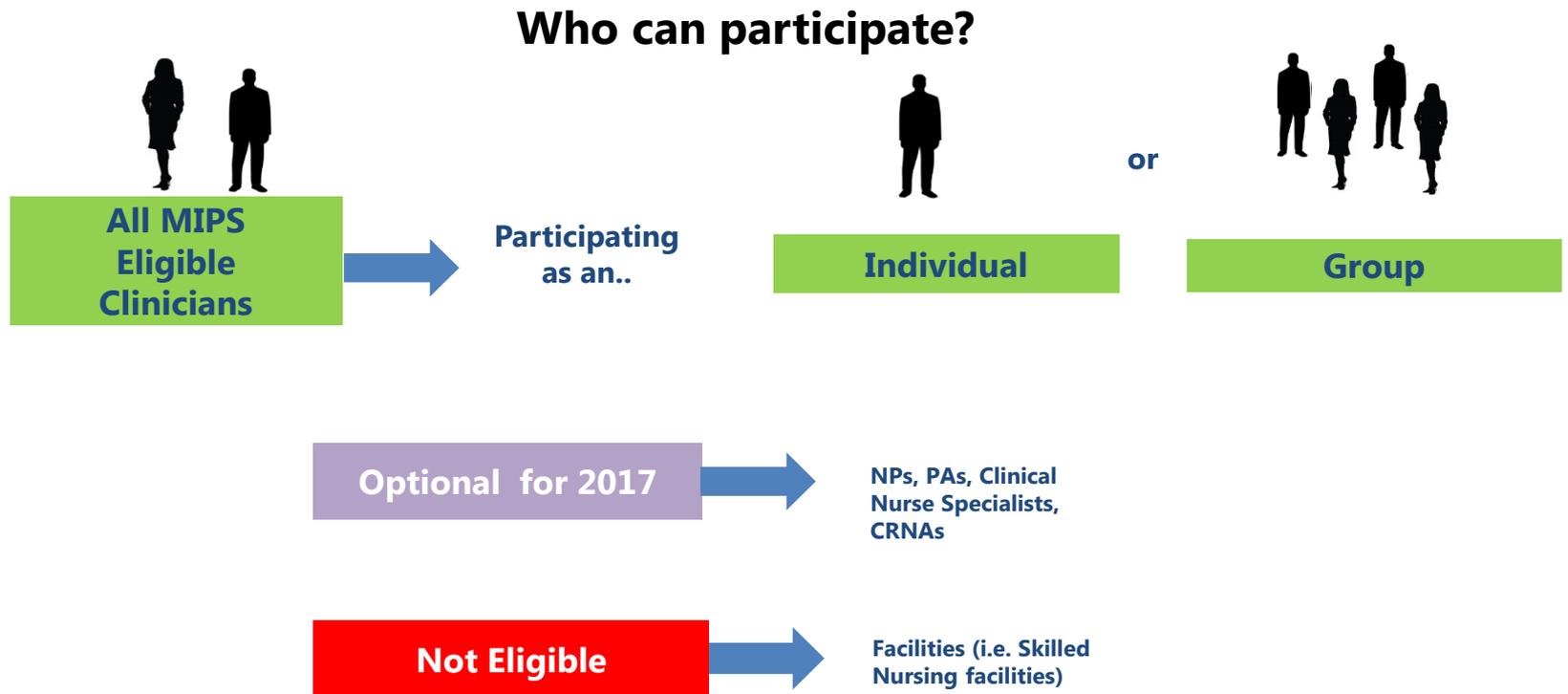
What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



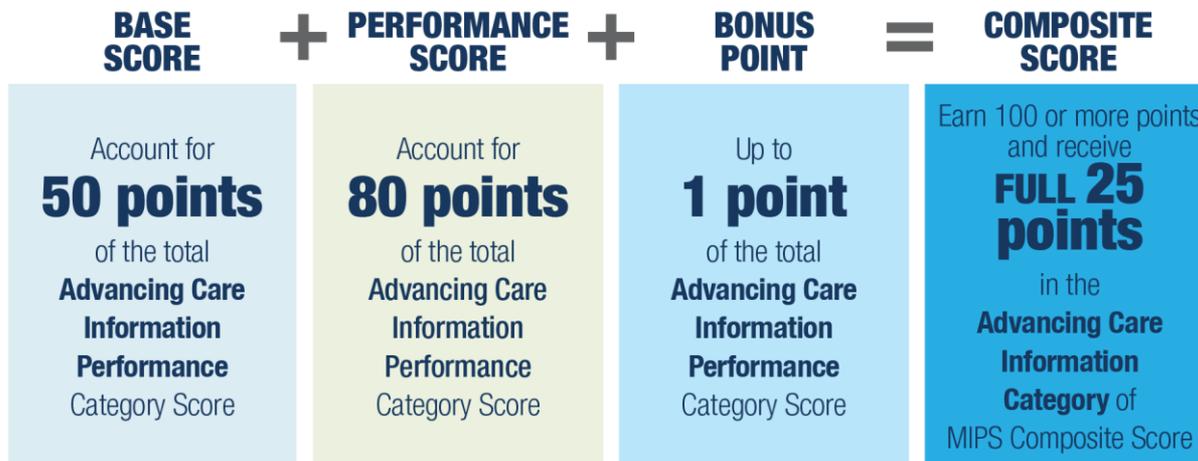
PROPOSED RULE

MIPS: Advancing Care Information Performance Category



PROPOSED RULE

MIPS: Advancing Care Information Performance Category



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

PROPOSED RULE
**MIPS: Advancing Care Information
Performance Category**

BASE SCORE

Accounts for
50
Percentage
Points
of the total
Advancing Care
Information
category score.

To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:



**Protect Patient Health
Information**
(yes required)



**Electronic
Prescribing**
(numerator/denominator)



**Patient Electronic
Access**
(numerator/denominator)



**Coordination of Care Through
Patient Engagement**
(numerator/denominator)



**Health Information
Exchange**
(numerator/denominator)



**Public Health and Clinical Data
Registry Reporting**
(yes required)

PROPOSED RULE
**MIPS: Advancing Care Information
Performance Category**

The Performance Score

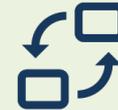
The performance score accounts for up to 80 percentage points towards the total Advancing Care Information category score



**Patient Electronic
Access**



**Coordination of Care Through
Patient Engagement**



**Health Information
Exchange**

Physicians and other clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Summary:

- ✓ **Scoring based on key measures of patient engagement and information exchange.**
- ✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**
- ✓ **Key Changes from Current Program (EHR Incentive):**
 - **Dropped “all or nothing” threshold for measurement**
 - **Removed redundant measures to alleviate reporting burden**
 - **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
 - **Reduced the number of required public health registries to which clinicians must report**
 - **Year 1 Weight: 25%**

PROPOSED RULE

MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
 <p>Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</p>	80 to 90 points depending on group size	50 percent
 <p>Advancing Care Information: Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</p>	100 points	25 percent
 <p>Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</p>	60 points	15 percent
 <p>Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</p>	Average score of all cost measures that can be attributed	10 percent

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories** on a **0-100 point scale** :



The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

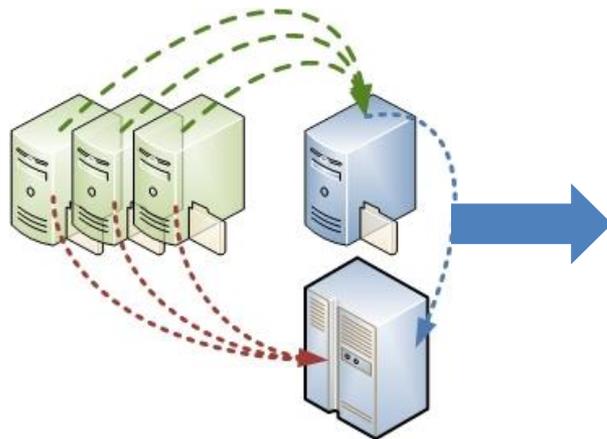
- ✓ MIPS composite performance scoring method that accounts for:
 - Weights of each performance category
 - Exceptional performance factors
 - Availability and applicability of measures for different categories of clinicians
 - Group performance
 - The special circumstances of small practices, practices located in rural areas, and non-patient-facing MIPS eligible clinicians

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
 Quality	50%	<ul style="list-style-type: none"> Each measure 1-10 points compared to historical benchmark (if avail.) 0 points for a measure that is not reported Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting Measures are averaged to get a score for the category
 Advancing care information	25%	<ul style="list-style-type: none"> Base score of 50 percentage points achieved by reporting at least one use case for each available measure Performance score of up to 80 percentage points Public Health Reporting bonus point Total cap of 100 percentage points available
 CPIA	15%	<ul style="list-style-type: none"> Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
 Resource Use	10%	<ul style="list-style-type: none"> Similar to quality

- ✓ Unified scoring system:
 1. Converts measures/activities to points
 2. Eligible Clinicians will know in advance what they need to do to achieve top performance
 3. Partial credit available

HOW DO I GET MY DATA TO CMS? *DATA SUBMISSION FOR MIPS*



PROPOSED RULE

MIPS Data Submission Options

Quality and Resource Use

Individual Reporting



Group Reporting



Quality

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ Claims

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ CMS Web Interface (groups of 25 or more)
- ✓ CAHPS for MIPS Survey



Resource use

- ✓ Administrative Claims (No submission required)

- ✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options

Advancing Care Information and CPIA

Individual Reporting



Group Reporting



- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR Vendor

- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR Vendor
- ✓ CMS Web Interface
(groups of 25 or more)



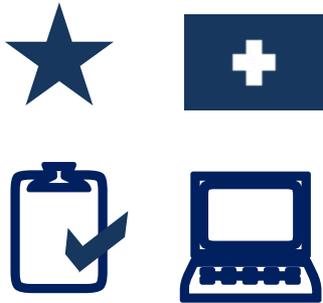
- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No
submission required)

- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ CMS Web Interface
(groups of 25 or more)

**PROPOSED RULE
MIPS PERFORMANCE
PERIOD & PAYMENT
ADJUSTMENT**

PROPOSED RULE

MIPS Performance Period



**MIPS Performance
Period
(Begins 2017)**

- ✓ All MIPS performance categories are aligned to a performance period of one full calendar year.
- ✓ Goes into effect in first year
(2017 performance period, 2019 payment year).

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
Performance Period		Payment Year						

PROPOSED RULE

MIPS: Payment Adjustment

- ✓ A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.
- ✓ A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.
- ✓ A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.



Quality



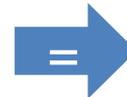
Resource
use



Clinical
practice
improvement
activities



Advancing
care
information



MIPS
Composite
Performance
Score (CPS)



PROPOSED RULE

MIPS: Payment Adjustment

- ✓ A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.
- ✓ An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an “additional performance threshold,” defined as the 25th percentile of possible values above the CPS performance threshold.



Quality



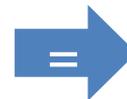
Resource
use



Clinical
practice
improvement
activities



Advancing
care
information

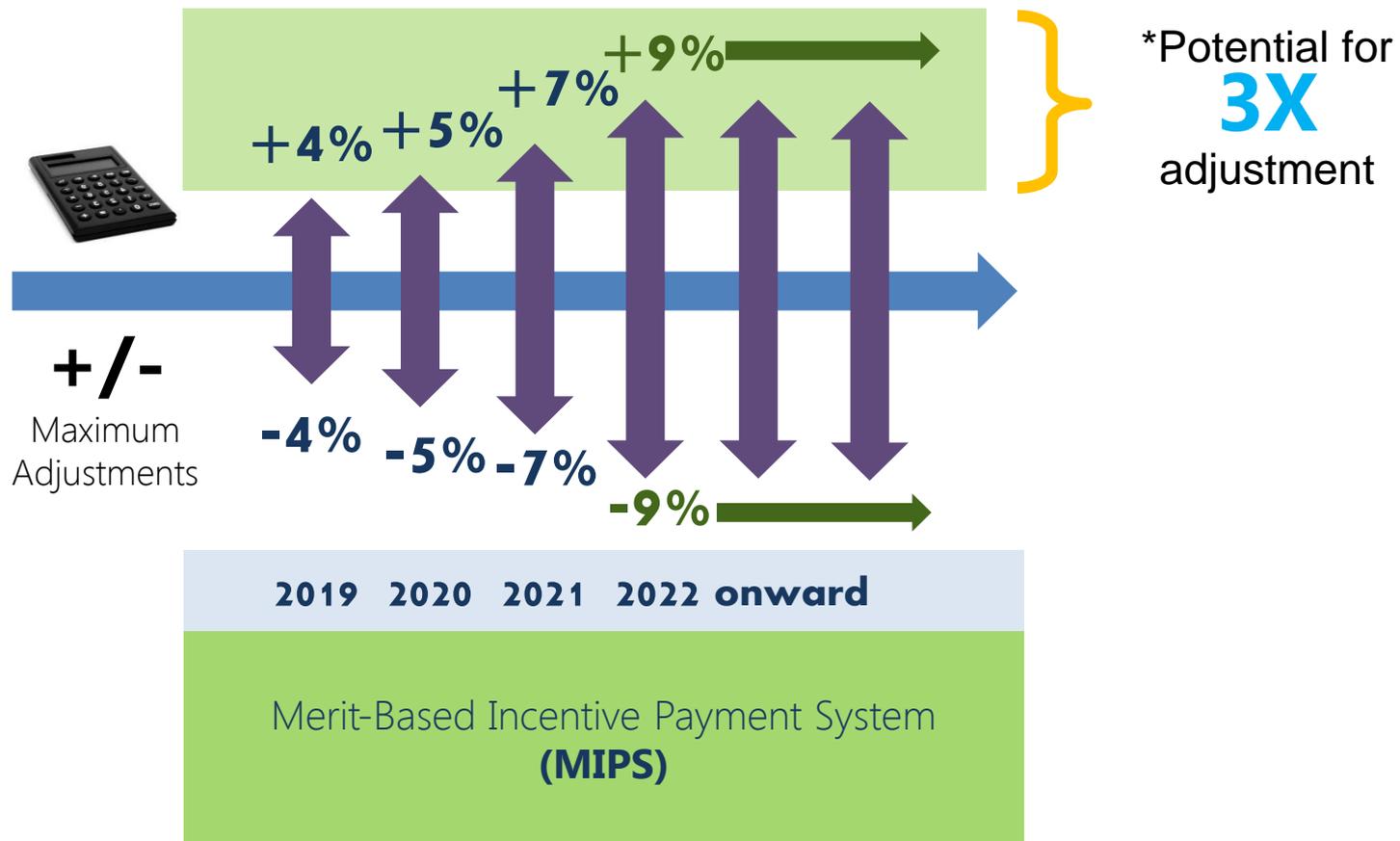


MIPS
Composite
Performance
Score (CPS)

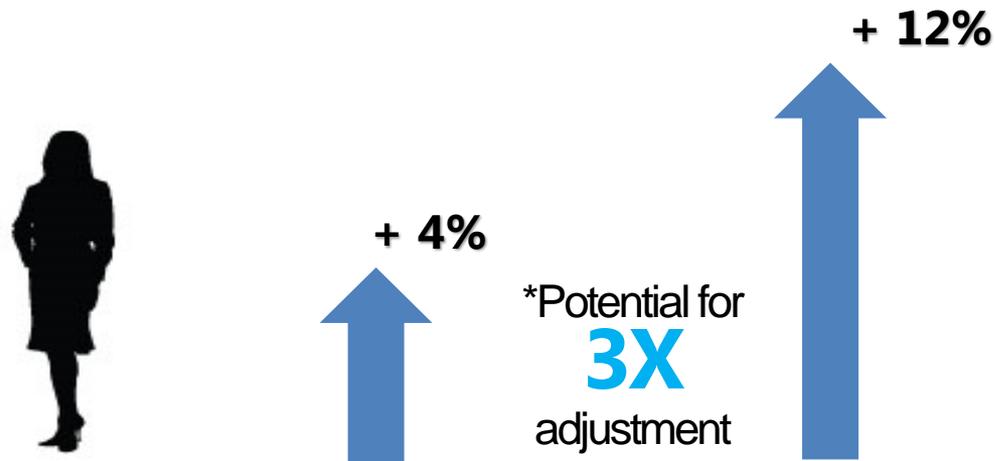


How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



MIPS: Scaling Factor Example

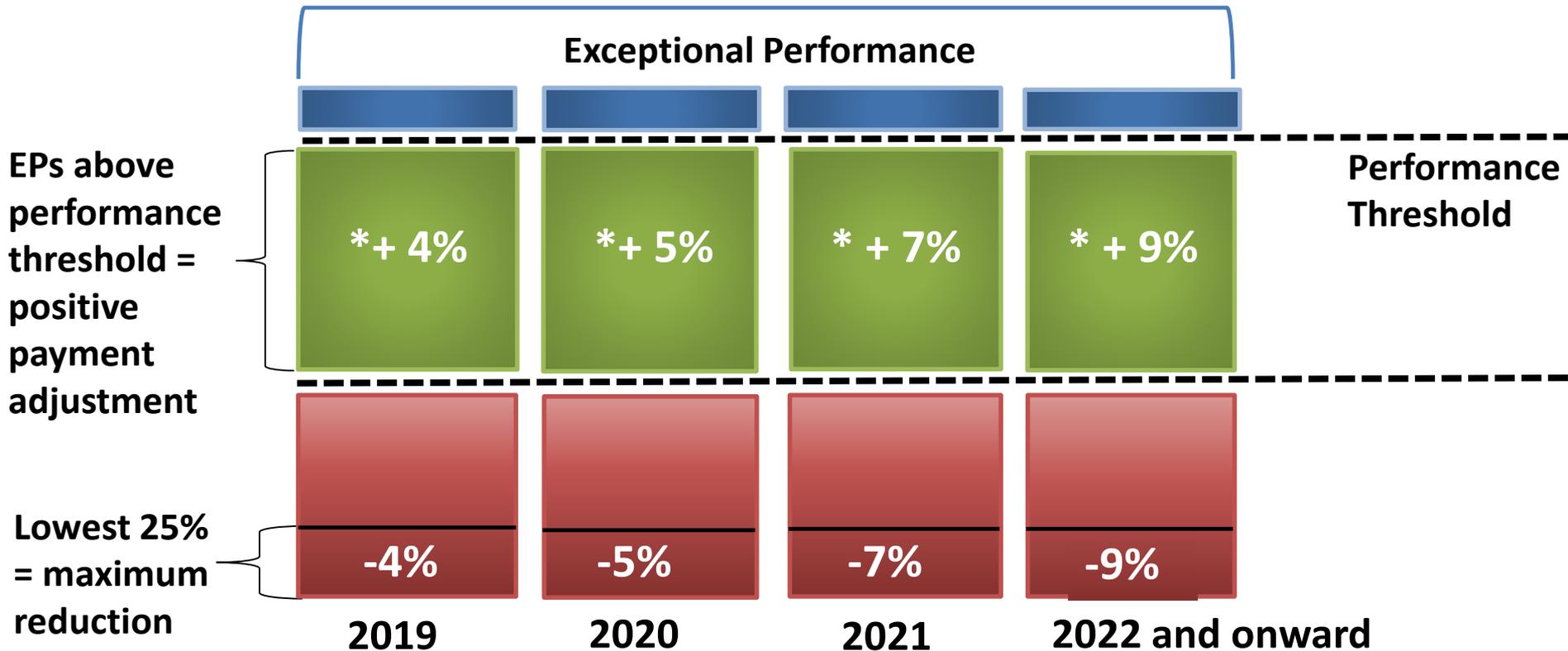


Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to \$500M available each year from 2019 to 2024

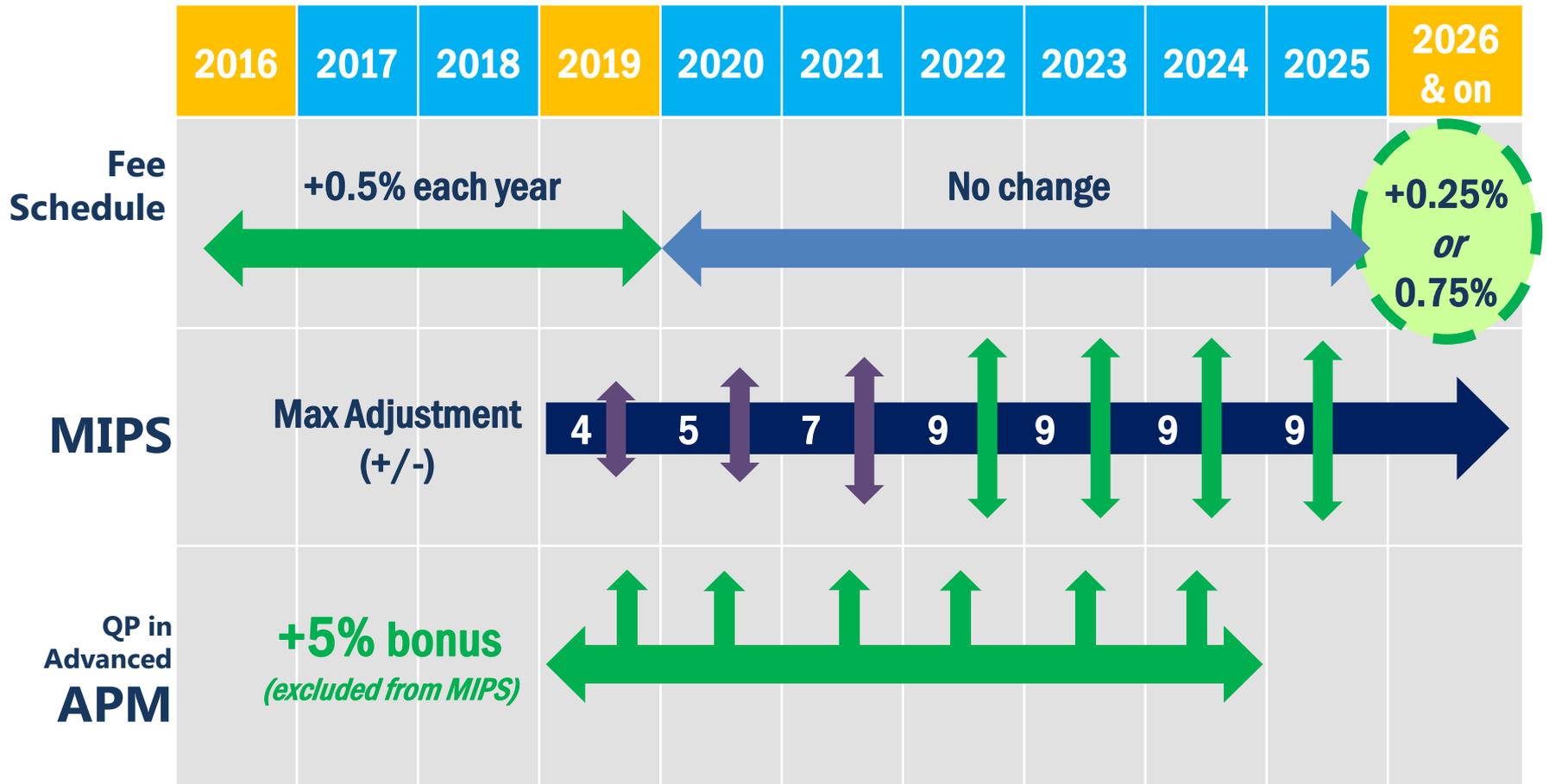


**MACRA allows potential 3x upward adjustment BUT unlikely*

A vintage brass alarm clock with two bells on top, resting on a wooden surface. The clock face is visible, showing numbers 1 through 12 and a small sub-dial. The clock is positioned on the right side of the frame. A semi-transparent green rectangular box is overlaid on the left side of the image, containing the text.

When will these Quality Payment Program provisions take effect?

Putting it all together:



TAKE-AWAY POINTS

- 1) The Quality Payment Program **changes the way Medicare pays clinicians** and offers financial **incentives** for providing high **value** care.
- 2) Medicare **Part B clinicians** will participate in the **MIPS**, unless they are in their 1st year of Part B participation, become QPs through participation in **Advanced APMs**, or have a low volume of patients.
- 3) Payment adjustments and bonuses will begin in **2019**.

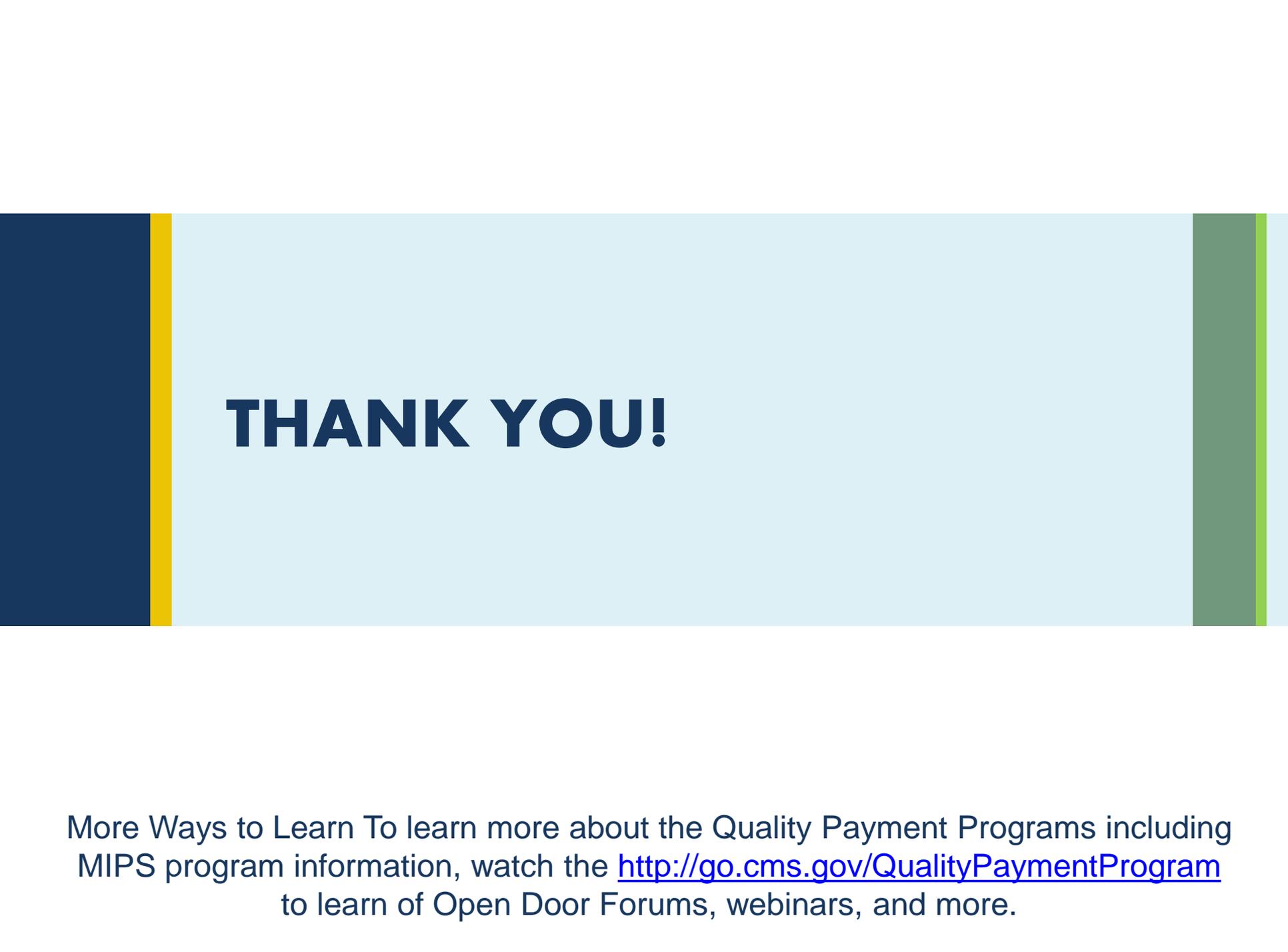
HOW TO SUBMIT COMMENTS

To submit comments on the Medicare Access and CHIP Reauthorization Act of 2015 Notice of Proposed Rulemaking, visit [The Federal Register](#) and follow the "Submit a comment" instructions.

The public can also submit comments in several other ways, including:

- By regular mail
- By express or overnight mail
- By hand or courier

Comments are due by **5:00 p.m. on Monday, June 27, 2016**



THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the <http://go.cms.gov/QualityPaymentProgram> to learn of Open Door Forums, webinars, and more.

The next vendor call will be held on **Thursday, June 23, 2016 from 12 – 1:30 p.m. ET**. CMS will share more information as it becomes available.

For access to presentations from previous workgroups visit the [CMS Events](#) page.