Collaboration of the Health IT Policy and Standards Committees

Policy and Standards Federal Advisory Committees on Health Information Technology to the National Coordinator

CMS Quality Payment Program Proposed Rule

Draft Recommendations to Joint Meeting of Health IT Policy and Health IT Standards Committees

Quality Payment Program Task Force

Paul Tang, co-chair

Christopher Ross, co-chair

June 8, 2016

Quality Payment Program Task Force Charge

- The Task Force was tasked with reviewing the MACRA proposed rule, with a specific focus on how the use of certified health IT by eligible clinicians can support value-based, quality-focused care under the Quality Payment Program.
- Members also assessed how the Quality Payment Program will encourage team-based approaches to care, and how certified health IT can facilitate these approaches.
- Within the NPRM, CMS is seeking comment on policy approaches within the Merit-based Payment System, the Alternative Payment Model scoring standard, and the Advanced Alternative Payment Models sections.
- The Task Force provided input on eligible clinicians' readiness to implement proposed policies and how certified health IT can best support participation and progression into advanced payment models.
- While subgroups provided input on specific questions, all members considered policy and technical feasibility implications for all questions.
- Some recommendations may best inform future program proposals, yet guidance provided for this NPRM could help prepare future policy development.

Quality Payment Program Task Force Membership

Member	Organization	Role
Paul Tang	**IBM Watson Health**	**Co-Chair**
Christopher Ross	**Mayo Clinic**	**Co-Chair**
John Travis	Cerner Corp.	Member
Michael Zaroukian	Sparrow Health System	Member
Mark Savage	National Partnership for Women & Families	Member
Joe Kimura	Atrius Health	Member
Anne Castro	BlueCross BlueShield of South Carolina	Member
Floyd Eisenberg	iParsimony, LLC	Member
Ginny Meadows	McKesson Provider Technologies	Member
Justin Fuller	Bon Secours Health System, Inc.	Member
Brent Snyder	Adventist Health System	Member
Charlene Underwood	Independent Consultant	Member
Marcy Carty	Blue Cross Blue Shield of Massachusetts	Member
Amy Zimmerman	Rhode Island Office of Health & Human Services	Member
Wendy Wright	Independent Nurse Practitioner	Member
Gretchen Wyatt	*HHS/ONC*	*ONC Lead*

Quality Payment Program Task Force Work Plan: "Speed Train"

Meeting Dates	Task
Tuesday, May 24, 10:00 am	Kick-off Meeting
Friday, May 27, 1:30 pm	Subgroup Two meeting: policy assessment
Friday, May 27, 3:30 pm	Subgroup One meeting: technical assessment
Friday, June 3, 2:00 pm	Draft recommendations
Wednesday, June 8 – Committee Meeting	***Present draft recommendations to the Committees***
Thursday, June 9, 10:00 am	Refine recommendations
Friday, June 17, 3:00pm	Refine recommendations
Thursday, June 23 – Committee Meeting	***Present recommendations to the Committees***
Monday, June 27 at 5 pm	**COMMENTS DUE TO CMS**
Thursday, June 30, 10:00 am	Discuss need for action on "future suggestions"

Task Force General Comments: Positive Responsiveness to Providers

- Overall, the proposed rule's objectives are good; they are responsive to stakeholder feedback, including:
  - Moving towards measuring and improving outcomes;
  - Reducing burden; and
  - Increasing flexibility.
- However, in the process of increasing flexibility, the proposed rule is too complex:
  - Hard to understand; and
  - Challenging to implement.

Task Force General Comments on QPP NPRM: Complex and Challenging

- The complexity of the program will be challenging for some stakeholders. CMS should be more clear and up-front about how the Quality Payment Program will have many positive results:
  - Burden reduction;
  - The ability for QPP to shift care to value-based programs across all payers; and
  - How high-priority goals (such as interoperability and patient engagement) will occur.
- It will be especially difficult for smaller providers to understand the rule and ensure that their practices, and use of health IT, complies with the rule.

Task Force General Comments: Timing

Timing Concerns:

- The proposed rule introduces many new options and requires participants to make choices in an unreasonably short timeframe.
- Without timely transparency about benchmarking, eligible clinicians cannot make appropriate practice and technology choices in time to participate effectively by the proposed performance period of 2017.
- Of particular concern is whether providers will have access to certified health IT that allows them to meet the MIPS performance categories.

Task Force General Comments: ACI Scoring

Advancing Care Information Scoring:

- Requiring participants to meet scoring and reporting for the Advancing Care Information category may set a high bar that discourages clinicians from participating in QPP.
- The diversity of choices in 2017 (between 2014 Edition and 2015 Edition Certification Criteria Rule, and Modified EHR Stage 2 and Stage 3 objectives and measures) may negatively impact technology developers' ability to support program participants, especially for the new categories of eligible clinicians, rural practices, those in underserved areas, and those in small practices.

Task Force General Comments: Small Providers

Small Providers:

- It will be especially difficult for smaller providers to understand the rule and ensure that their practices, and use of health IT, comply with the requirements.
- Complexity will also be a barrier to eligible clinicians deciding whether, and how, to migrate toward APM participation.

Task Force General Comments: Group Reporting

Group Reporting:

- Practices deciding whether to report as a group or as individuals for MIPS are highly dependent on many factors:
  - Timing required for making decisions by CMS deadlines;
  - Basic processes, including selection of reporting mechanisms;
  - Impacts on clinical workflow;
  - Measure selection for optimal performance/benchmarking; and
  - Determining which providers in multi-group practice fit in APMs or in MIPS.
- These decisions will have significant impacts for practices.
- Helping practices gain a clear understanding of requirements, timelines and technology availability is critical.

Task Force Draft Recommendations: Simplify and Clarify (1 of 4)

1. **Improve Clarity**: In order to facilitate a better understanding of the final rule and to simplify its implementation, we recommend including graphical illustrations where possible to clarify the elements of the program and their inter-relationships. These could include the following:

- A figure that depicts the overarching goals of MACRA and how the program components will achieve their objectives to transform care.
- A graphical diagram mapping the current programs to the MIPS categories and to proposed APMs, to highlight how the new programs provide additional flexibility and reduce burden for the eligible clinician.
- A graphical depiction of how a clinician would transition from the MIPS program to an APM, to highlight the benefits of moving to an APM.

Task Force Draft Recommendations: Focus on Outcomes (2 of 4)

2. **Outcomes, Not Processes**: Focus policies more distinctly and clearly on the program's desired outcomes (especially interoperability and patient engagement) and how each component aligns to drive delivery system reform.

- Ensure that each requirement throughout each program area clearly drives behavior toward care coordination, patient engagement, and meaningful information sharing.
- Leverage HIE-sensitive performance measures to reward meaningful information sharing.
- Focus on the outcomes that matter to patients and consumers, and incentivize processes that are most important to them.
- Motivate clinicians to move towards advanced payment models by more strongly and clearly rewarding innovation and learning, rather than prescribing specific processes and accounting ("check the box").

Task Force Draft Recommendations: Tell a Compelling Story (3 of 4)

3. **Tell a Compelling Story** : CMS needs to convincingly explain how participating Eligible Clinicians will be benchmarked and how the payment incentives and adjustments will be applied, where the policies are clear and the scoring methodology is easy to understand.

- Focus ACI on health IT functionality that is clearly connected with interoperability, care coordination, and patient engagement.
- The Final Rule should more strongly reward opportunities for innovation to expand access to care, such as through telehealth, incentives for rural providers, and for those in underserved areas.
- Simplify the glide path for participation in APMs. Make the APM Scoring Standard simpler so that substantial education is not required to understand to encourage broad participation.
  - » Create education and explanations similar to outreach developed by Regional Extension Centers for HITECH
- Identify more pathways for small and rural providers to better engage in the program and in priority goal achievement.

Task Force Recommendations: Tell a Compelling Story (3 of 4, Con't.)

Improve the CPIA Category:

- CPIA should avoid being prescriptive, since it is a process requirement. CPIA could serve as a "test bed" for innovation for activities which might later be incorporated in APMs. Some examples of flexible options to consider for this statutory section:
  - » Explore opportunities to allow specialty-specific quality improvement activities, performed to satisfy professional Maintenance of Certification requirements, to be deemed as partial satisfaction of the CPIA requirement.
  - » By testing health IT use that supports innovations in care within the CPIA category, HHS could identify high impact functionalities for consideration in future certification requirements. In this way, QPP and the marketplace would have the ability to incorporate innovation and scientific advancement that truly improves care.

Task Force Draft Recommendations: Promote Interoperability (4 of 4)

4. **INTEROPERABILITY**: MACRA offers an excellent opportunity to promote widespread interoperability among multiple stakeholders in health care, which could be more prominently promoted by the proposed rule. Encourage private payers to construct value-based programs that align with the Quality Payment Program and to build in incentives to submit electronic clinical data.

- The Quality Payment Program could facilitate greater partnership among providers and public and private payers to reward information sharing:
  - Build a common infrastructure for data submission that can be used by any payer;
  - Simplify and standardize quality measures.
- Create a pathway for providers to move toward wholly electronic information collection, one that allows for equivalent information to be widely distributed to all qualified entities that request it.
- Make sure the most important information for quality measurement and Improvement is submitted to QCDRs, even if this is not imported electronically. Focus on the information first, and perfect the process over time.

Questions and Feedback from Committee Members

The Office of the National Coordinator for Health Information Technology

Quality Payment Program Task Force

Paul Tang , co-chair

Cris Ross, co-chair

For additional resources, please visit CMS' Quality Payment Program website:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html

Quality Payment Program overview slides available here:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf