Collaboration of the Health IT Policy and Standards Committees

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

Quality Payment Program Task Force

Paul Tang, co-chair
Christopher Ross, co-chair

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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 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.

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 has become too complex:
  - Hard to understand; and
  - Challenging to implement.

Task Force General Comments: Complex and Challenging

- The proposed rule introduces many new options and requires participants to make choices in an unreasonably short time frame.
  - Especially challenging for smaller providers to understand and comply with health IT and other requirements
  - Complexity will be a barrier for many to migrate toward APM participation
  - Requiring participants to meet Advancing Care Information category requirements for certified health IT, reporting, and scoring decisions may discourage clinicians from participating in the Quality Payment Program

Task Force General Comments: Help Clinicians Gain Clear Understanding

- Decisions on reporting as groups or individuals, measure selection, and whether to participate in MIPS or APMs will have significant impact on practices.
- CMS should make the final rule explicitly clear to achieve its goal of reduced burden and increased flexibility
  - » Make the program overall, and its individual components, easier to understand and implement
  - » Simplicity and clarity will encourage more providers to participate

Feedback from Joint Collaboration Meeting June 3

- Build on key points presented in draft recommendations with solid examples of how final rule should be improved
- Encourage greater participation in APMs by giving Qualified Providers credit to providers participating in non-Advanced APMs (e.g., MSSP Track 1) in recognition that participation requires long on-ramp process
- Task Force should consider proposal recommending that CMS delay implementation (performance year) for six months-one year beyond January 2017
- Encourage CMS to set quality improvement/measures goals, and invite commercial payers to work towards achieving them in parallel
- Support Task Force recommendation that goal of reduced burden for providers should be considered more broadly by CMS within the final rule
  - » Align reporting mechanisms and timing across payers
  - » Align quality measures within programs with standardized value sets
- Task force should draw clear examples where the intent, action of the rule lack alignment on burden reduction, simplification, flexibility, and alignment

Detailed Comments and Focus Areas for Final Rule Improvement

- Increase accessibility throughout the final rule and communicate a compelling story that is relevant to clinicians and consumers.
  - » Develop additional visual materials to help providers understand the rule
  - » Further revise the ACI category for clarity
  - » Provide additional clarity around the CPIA Inventory

Comparison of Existing Program and Proposed QPP Requirements
Physician Quality Reporting System -> Quality Category

PQRS in 2016	Quality in 2017
9 CQMs	6 CQMs 1 of which must be a cross-cutting measure, and 1 of which must be an outcome measure, or Another high priority measure if outcome is unavailable
CQMs must cover at least 3 of the 6 National Quality Strategy Domains	No domain requirement
Electronic reporting is the preferred (but not required) submission option.	Electronic reporting is an option which is incentivized by offering 1 potential bonus point per eCQM, up to 5% of total score, when reporting via "end-to-end" electronically. May report via CEHRT, QCDR, registry, or third-party vendor
Certification is required for electronic reporting.	Electronic reporting may take many forms as long as the data is captured using certified EHR technology.

Comparison of Existing Program and Proposed QPP Requirements EHR Incentive Program -> Advancing Care Information Category, continued

For EHR Incentive Programs in 2016 a provider must	Comparison	For MIPS ACI in 2017 an eligible clinician must	Comparison	For MIPS ACI in 2018 an eligible clinician must
Use CEHRT 2014 Edition	=	Use CEHRT 2014 Edition or 2015 Edition	=	Use CEHRT 2015 Edition
Do a security risk analysis or review	=	Do a security risk analysis or review	=	Do a security risk analysis or review
Attest that they are not info blocking	=	Attest that they are not info blocking	=	Attest that they are not info blocking
Implement 5 CDS plus drug-drug, drug-allergy	↓	Have the function for implementing CDS including drug-drug, drug-allergy	=	Have the function for implementing CDS including drug-drug, drug-allergy
Write 50% of prescriptions electronically	↓	Write at least 1 prescription electronically	=	Write at least 1 prescription electronically
Use CPOE for 60% of medication orders	↓	Have the function for CPOE for medication orders	=	Have the function for CPOE for medication orders
Use CPOE for 30% of lab orders	↓	Have the function for CPOE for lab orders	=	Have the function for CPOE for lab orders
Use CPOE for 30% of radiology orders	↓	Have the function for CPOE for radiology **Optionally** may include all diagnostic imaging orders	=	Have the function for CPOE for radiology or diagnostic imaging orders

Comparison of Existing Program and Proposed QPP Requirements
EHR Incentive Program -> Advancing Care Information Category, continued

For EHR Incentive Programs in 2016 a provider must	Comparison	For MIPS ACI in 2017 an eligible clinician must	Comparison	For MIPS ACI in 2018 an eligible clinician must
Send or respond to a secure message for at least 1 patient	=	Send or respond to a secure message for at least 1 patient	=	Send or respond to a secure message for at least 1 patient
Send an electronic summary of care document for 10% of transitions of care	↓	Send an electronic summary of care document for at least 1 transition of care	=	Send an electronic summary of care document for at least 1 transition of care
Conduct medication reconciliation for at least 50% of transitions and referrals	↓	Conduct medication reconciliation for at least 1 transition or referral **Optionally** may conduct medication, medication allergy and problem list reconciliation	↑	Conduct medication reconciliation for at least 1 transition or referral **Required** Conduct medication, medication allergy and problem list reconciliation
Report to at least 2 public health registries	↓	Report on immunizations	=	Report on immunizations
Not applicable	N/A	**Optional** Incorporate patient generated health data, or data from a "non-clinical" setting, for at least 1 patient	↑	**Required** Incorporate patient generated health data, or data from a "non-clinical" setting, for at least 1 patient
Not applicable	N/A	**Optional** Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received	↑	**Required** Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received

Detailed Comments and Focus Areas for Final Rule Improvement

- Identify opportunities to further simplify the final rule and reduce burden for eligible clinicians.
  - » Agree with reducing the number of objectives for ACI (vs the "alternative")
  - » Create an "on-ramp" for the ACI category for eligible clinicians that have not participated in the EHR Incentive Programs
    - – Possible strategies could include the following:
      - Adopt a shorter (6-month) reporting period
      - Reweight ACI scoring to other MIPS categories until 2019 for newly eligible clinicians such as behavioral health providers, allowing additional time to gain experience with CEHRT and ACI objectives and measure reporting

Detailed Comments and Focus Areas for Final Rule Improvement, continued

- Significantly reduce process-oriented measures in the CPIA category and build on activities clinicians already are completing
  - More clearly integrate the use of health IT into the CPIA category
  - Possible strategies could include the following:
    - CPIA as a “test bed” for innovation to identify how activities will lead to improved outcomes and readiness for APM participation

Detailed Comments and Focus Areas for Final Rule Improvement, continued

- Reduce reporting burden for providers in APMs and assist providers in decision-making around APM participation
  - Possible strategies could include the following:
  - Allow an eligible clinician that achieves QP status to automatically satisfy MIPS reporting for the following year if they indicate they plan to continue participation in an advanced APM, so that the eligible clinician is exempted from MIPS reporting for that year.
  - Convey whether new models will have Advanced APM status when they are first publicly released, so that eligible clinicians will have that information when determining participation in new models.

Detailed Comments and Focus Areas for Final Rule Improvement, continued

- Focus policies more distinctly and clearly on the Quality Payment Program's desired outcomes, especially interoperability and patient engagement.
  - » Establish additional bonuses for performance on information sharing measures
    - – Possible strategies could include the following:
      - Award bonus points to the composite performance score, as well as individual MIPS categories, for eligible clinicians with marked improvement or achievement in high-priority areas
      - Tailor rewards to outcomes achievement (e.g., HIE-sensitive outcomes), not process measures that track certain capabilities
  - » Develop effective methods to reward clinicians for improvement
    - – Possible strategies could include the following:
      - Calculate progress towards achievement of the target goal on a relative basis so that baseline good performance is not penalized

Detailed Comments and Focus Areas for Final Rule Improvement, continued

- Take further advantage of opportunities under MACRA to promote more seamless measurement and reporting infrastructure across stakeholders
  - Possible strategies could include the following:
    - Increase bonuses for electronic reporting within the MIPS Quality performance category from 5% to 10% for quality measurement data derived from the use of CEHRT
    - Clarify where certified technology is required for third-party data submission methods
    - Increase bonus from 1 to 2 points for using eCQMs for high-priority reporting of patient safety, efficiency, patient experience, and care coordination measures, outcome measure, or cross-cutting measure
    - Clarify links within the rule to CMS measure development initiatives
    - Allow sufficient time for developers to implement new eCQMs

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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