Quality Payment Program Task Force

 Draft Recommendations: Comments on the CMS Proposed Rule

General Comments:

1. Overall, the proposed rule is responsive to stakeholder feedback by moving clinicians towards measuring and improving outcomes, while seeking to reduce burden and increase flexibility.
	1. However, in striving to meet these goals, the proposed rule has become too complex to understand and to implement, and will be challenging for many stakeholders to confidently engage in measure selection, electing between MIPS or APM participation, and selecting practice improvement activities.
2. The proposed rule introduces many new options and requires participants to make choices in an unreasonably short timeframe. Without timely transparency about how eligible clinicians will be benchmarked, they cannot make appropriate practice and technology choices in time to participate effectively by the proposed performance period of 2017, particularly if they do not have access to certified health IT that allows them to meet the MIPS performance categories.
	1. 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.
	2. Requiring participants to meet scoring and reporting for the 2018 Advancing Care Information category may set a high bar that discourages clinicians from participating in the program. Ironically, the diversity of choices in 2017 (between 2014 Edition and 2015 Edition CEHRT, 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 not within large organizations.
3. Groups deciding whether to report collectively or as individuals for MIPS are highly dependent on many factors (e.g., timing of decisions, basic processes including selection of reporting mechanisms, impacts on clinical workflow, measure selection, which providers in multi-group practice fit in APMs or in MIPS) and will have significant impacts for practices; helping them gain a clear understanding of requirements, timelines and technology availability is critical.

Draft Recommendations:

1. 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, such as the following:
* A figure that depicts the overarching goals of MACRA and how the program components achieve their objectives to transform care
* A graphical diagram mapping the current programs to MIPS and APM to highlight how the new programs provide additional flexibility and reduce burden for the eligible clinician
* A graphical depiction of how a clinician transitions from the MIPS program to an APM, highlighting the benefits of moving to an APM
1. 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”).
1. CMS needs to establish a compelling story that explains 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 HIT functionality that is clearly connected with interoperability, care coordination, and patient engagement.
	+ Consider eliminating optionality within the ACI category of 2014 Edition CEHRT and EHR Modified Stage 2 objectives and measures within the 2017 performance period to reduce complexity and allow participants and developers time to test and prepare to meet 2018 requirements.
* 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 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, the program and marketplace would have the ability to incorporate innovation and scientific advancement that truly improves care.
* Rule should more strongly reward opportunities for innovation, such as through telehealth and incentives for rural providers and those in underserved areas to expand access to care.
* Simplify the glide path for participation in APMs. Make APM Scoring Standard simpler so that substantial education is not required to understand, similar to that developed by Regional Extension Centers for HITECH, to encourage broad participation and identify pathways for small and rural providers to better engage in program and priority goal achievement.
1. MACRA offers an excellent opportunity to promote widespread interoperability among multiple stakeholders in health care, which could be more prominently exploited 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 amongst providers and public and private payers to reward information sharing, by building a common infrastructure for data submission that can be used by any payer, and simplifying and standardizing 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.

**(SUBGROUP DISCUSSION QUESTIONS – For BACKGROUND USE)**

The Task Force was also tasked with addressing the following questions about the proposed objectives under MIPS and APM:

1. Does the NPRM’s approach for the program sufficiently reduce burden on Eligible Clinicians, both within the Advancing Care Information (ACI) category and across the Quality Payment Program, while increasing overall flexibility, consistent with the policy vision for the program? Does the proposed approach adequately promote interoperability, care coordination, and patient engagement?
* Clarify the options that clinicians have a choice in 2017 over which certification edition and which MU stage objectives and measures are selected (2014/2015 edition, MU Mod 2/Stage 3) and their implications on ACI performance category.
* Timelines for compliance with 2017 performance period may be too difficult for new participants as well as some current EHR incentive program participants. Recommend that existing MU-compliant clinicians be allowed to continue use of their existing MU-compliant HIT in 2017.
* Be fully transparent about when clinicians must make decisions on group versus individual reporting, what performance benchmarks will be, and what workflow changes are necessary to report eCQMs and CPIA activities, for example.
1. Will the proposal for the overall program, as well as within the ACI category specifically, adequately incentivize continued health IT adoption and use to support overall policy objectives of interoperability, care coordination, patient engagement, and widespread adoption of certified health IT? Can certified health IT facilitate group reporting within MIPS to reduce burden and improve team-based inclusion of both eligible clinicians and others in value-based care?
* Need a greater focus on the actual use of health IT, with more stringent measures within ACI and overall MIPS composite performance scoring over time to achieve high-priority policy goals. Example?
* Interoperability approaches for payment, care coordination, and patient engagement are very different, and determining which goals need to be met first will influence how health IT is developed.
* CEHRT availability and eCQM reporting remain challenges for certain Eligible Clinicians, who also will have difficulty participating in APMs. Example?
* Increase incentives for rural health providers, use of telehealth, and reward providers engaged in active collaboration of direct resource and information sharing
* Help providers understand timing and scoring implications for reporting as individuals or as a group, particularly to determine whether they will earn higher performance scores in ACI and in the composite performance score
* Establish clear processes and policies that introduce new program requirements in measured fashion over time to not cause undue disruption or Eligible Clinician discouragement
* Important to monitor and promote health IT requirements in APMs to ensure continued progress in health IT use. Since interoperability is a top priority, all clinicians should be required to focus on HIE measures. More structure, and less flexibility or optionality as proposed, may also have the benefit of encouraging other payers to align their HIE capabilities with the direction set for Medicare under this Rule.
* Make it possible for clinicians to submit advancing care information data for other payers through the same mechanisms as proposed in MIPS – qualified registry, EHR, QCDR, and

CMS Web Interface submission methods – and at the same time permit other payers to use these mechanisms to exchange data with clinicians (e.g., if a clinician submits information to a qualified clinical data registry, or QCDR, under MIPS, and that clinician becomes part of an APM entity in an Advanced APM model, he or she should continue using the QCDR; if that clinician is part of an APP entity participating in an Other Payer advanced APM, he or she should also be using the QCDR, and the other payer should be able to receive data through the QCDR).

* Suggest eliminating CPIA, if possible. More effective to be done by professional associations with credit in MIPS given.
* Providers will need substantial education and guidance on how group reporting will work (timing of decisions, basic processes including selection of reporting mechanisms, impacts on clinical workflow, measure selection, which providers in multi-group practice fit in APMs or in MIPS). Numerous suggestions about group reporting, may want to combine.
* Rule should more strongly reward opportunities for innovation, such as through telehealth and incentives for rural providers to expand access to care.
1. How will flexibility proposed within the ACI category impact participation by different groups of Eligible Clinicians? For instance, will the introduction of the proposed base score component encourage program participation by Eligible Clinicians who are new users of certified health IT? Will the proposal for performance scoring incentivize achievement and improvement by more experienced Eligible Clinicians?
* To simplify the ACI category, move measures that are new compared to Meaningful Use (e.g., reconciling clinical information) from the base to the performance score incentive area and continually focus on outcomes, rewarding the processes that matter to patients (safety, easy access to care through telehealth, etc.).
* Understanding the proposed Base scoring is still a challenge. Although thresholds are effectively removed from the base score, clinicians still will need to understand how their choices in reporting in this category and other MIPS categories will impact their overall composite performance score.
* Current tables are confusing. A better approach may be to present how each clinician group (new entrants, experienced participants, rural, group, small practices) likely would be scored.
1. Does the NPRM’s certified health IT adoption requirements for each program achieve the stated policy goal of enabling Eligible Clinicians to transition smoothly between MIPS and APMs? Will the proposed APM scoring standard support the stated policy goals to reduce MIPS reporting burden for providers in APMs?
* Simplify the glide path for participation in APMs. Make APM Scoring Standard simpler so that education is not required to understand, similar to that developed by Regional Extension Centers for HITECH, to encourage broad participation and identify pathways for small and rural providers to better engage in program and priority goal achievement.
* CPIA should be better structured to serve as a “test bed” for innovation. This category could serve as a framework for which activities could be included in new APMs, and assessment of which activities truly improve care coordination and patient engagement.
1. Are there clarifications to the policies that could support adoption of electronic reporting for CQMs and to encourage QCDRs and other third-party entities to adopt and implement certified health IT? For future program evolution, what should be considered as the next step for continued development of health IT to support specification, testing, and certification of clinical quality measures?
* CEHRT proposed bonus scoring is too low, especially for first performance period. A recommendation would be to increase this to 10% for first performance year, decreasing yearly afterward, to meet stated policy goals of better information use and interoperability.
* Substantially reward use of/reporting on a reduced quantity of eCQMs that are most beneficial to patient care and that address the most critical outcomes. This will incentivize more providers to select them and have health IT products that support them.
* Make sure the most important information for Quality Measurement and Improvement is traveling to the QCDR, even if this is not imported electronically. Focus on the information first, and perfect the process over time.
1. As certified health IT capabilities evolve over time, how should new capabilities be incorporated into the MIPS program (for instance, as optional activities within the Clinical Practice Improvement Activities inventory) and requirements for APMs? How can MIPS and APMs facilitate adoption of emerging standards-based health IT over time?
* By focusing the QPP to reward outcomes, health IT software will rapidly innovate to support this approach. Establish a narrow certification program to fully support the high-priority goals, rather than process accounting.
* New eCQMs need to center on whether users have access to the information they need at the right time, rather than adding process measures.
* 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 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, the program and marketplace would have the ability to incorporate innovation and scientific advancement that truly improves care.
* Rule should more strongly reward opportunities for innovation, such as through telehealth and incentives for rural providers and those in underserved areas to expand access to care.