NQRN Update Public Call

Impact of Federal Regulations on Registries

July 10, 2017

NQRN® National Quality Registry Network

Agenda

- Welcome, Introductions and Housekeeping   Chrystal Price, 10 minutes

- Presentation   Dan Green, MD, 15 minutes

- Presentation   Danielle A. Lloyd, MPH 15 minutes

- Moderated Q&A   Kathleen Hewitt, 15 minutes

- Wrap-up   Chrystal Price, 5 minutes

NQRN® National Quality Registry Network

Speakers and Moderator

Presenters

Dr. Dan Green, MD, FACOG
Medical Officer, Office of Clinical Standards and Quality
Centers for Medicare and Medicaid Services

Danielle A. Lloyd, MPH
Vice President, Policy and Advocacy
Premier, Inc.

Moderator

Dr. Kathleen Hewitt, DNP, CPHQ, AACC
Associate Vice President,
Registries and Quality Initiatives
American College of Cardiology

NQRN® National Quality Registry Network

Housekeeping

- The webinar is being recorded
- The slides and a link to the recording will be posted at thepcpi.org
- For the Q&A portion of the webinar, please enter your questions into the chat window

NQRN® National Quality Registry Network

Objectives

- Quality Payment Program Review: MIPS, Advanced APMs and 2018 Proposed Rule
- Review of QCDR Measure Submission Process
- New Submission Modalities
- Measure Development Funding Opportunity
- 21st Century Cures Act Overview

MERIT-BASED INCENTIVE PAYMENT SYSTEM OVERVIEW

Dr. Daniel Green, CMS

Medicare Access and CHIP Reauthorization Act of 2015

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlines a patchwork collection of programs (Physician Quality Reporting System, EHR Incentive Program, and Value-based Payment Modifier) with a single system, the Quality Payment Program, where an eligible clinician can be rewarded for better, more efficient care.

    - Under the combination of the previous programs, eligible clinicians would have faced a negative payment adjustment as high as 9% total in 2019, but the MACRA ended those programs, reduced the potential negative payment adjustments in the early years, and streamlined the overall requirements.

Quality Payment Program

- The Quality Payment Program (QPP) is designed to:
  - Reform Medicare Part B payments for more than 600,000 clinicians
  - Improve care across the entire health care delivery system

- Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
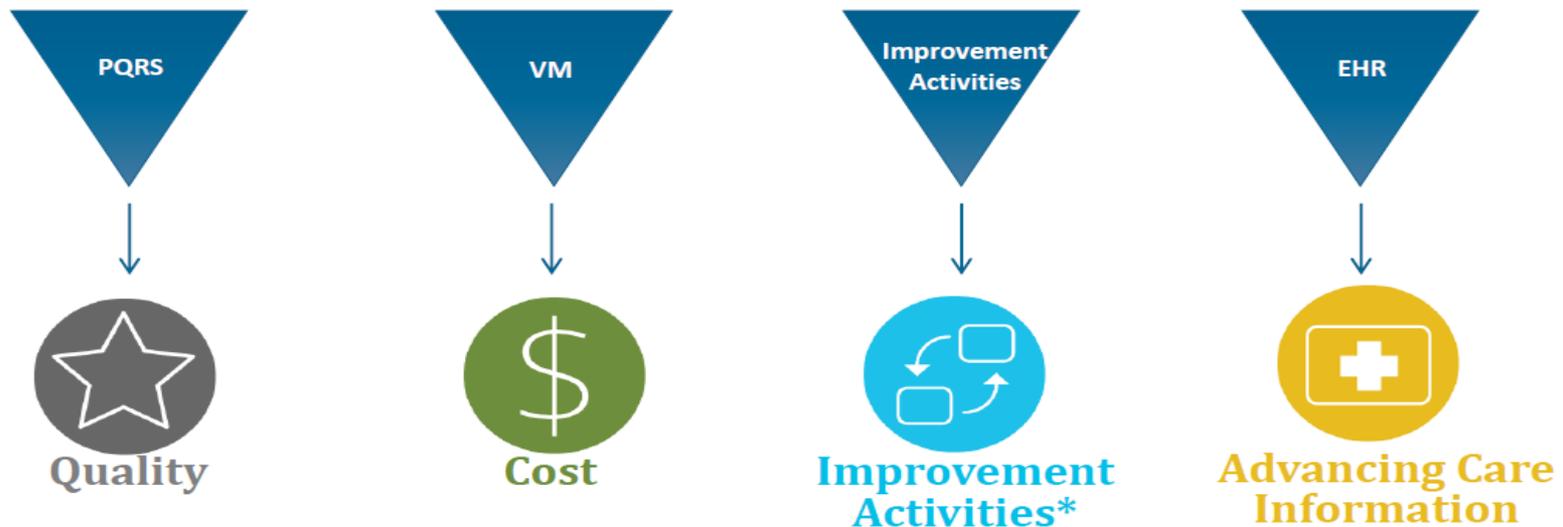
OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

Merit-based Incentive Payment System

- ## What is the Merit-based Incentive Payment System?

  - Moves Medicare Part B clinicians to a performance-based payment system
  - Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
  - Reporting standards align with Advanced APMs wherever possible

- ## MIPS has four connected performance categories that will affect your Medicare payments:

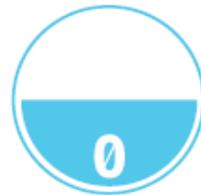| PQRS → Quality | VM → Cost | Improvement Activities → Improvement Activities* | EHR → Advancing Care Information |

Pick Your Pace

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test
Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year
Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year
Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS Timeline

| Performance year | submit | Feedback available | adjustment |

2017
Performance Year

Performance: The first performance period opened January 1, 2017 and closes December 31, 2017. During 2017, eligible clinicians will submit quality data to their QCDR.

March 31, 2018
Data Submission

Send in performance data: To potentially earn a positive payment adjustment under MIPS, qualified registries must send in the eligible clinician's data by the deadline, March 31, 2018.

Feedback

Feedback: Medicare gives eligible clinicians feedback about their performance after the QCDR has submitted their data.

January 1, 2019
Payment Adjustment

Payment: Eligible clinicians may earn a positive MIPS payment adjustment beginning January 1, 2019 if they submit 2017 data by March 31, 2018.

Payment Adjustments

Final Score	Payment Adjustment
>70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Who Can Participate?

- Medicare Part B clinicians billing more than $30,000 a year AND providing care for more than 100 Medicare patients a year.

  - These clinicians include:

Physicians	Physician Assistants	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetists

- Clinicians who are not included in MIPS now, may choose to voluntarily submit data individually to Medicare to learn, to obtain feedback on quality measures, and to prepare in the event MIPS is expanded in the future. Clinicians who submit data voluntarily will not be subject to a positive or negative payment adjustment.

Participation Exemption

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

  OR

- See 100 or fewer Medicare Part B patients a year

- For the 2017 MIPS performance period and the 2019 MIPS payment year, CMS will make low-volume status determinations based on satisfying either low-volume threshold in either one of the following evaluation periods:
  - Historical claims data:
  - September 1, 2015 – August 31, 2016
  - Performance period claims data: September 1, 2016 – August 31, 2017

Reporting Options

	Individual	Group
Quality	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Claims	✓ QCDR *(Qualified Clinical Data Registry)* ✓ Qualified Registry ✓ EHR ✓ Administrative Claims ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey
Advancing Care Information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
Improvement Activities	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor

QUALIFIED CLINICAL DATA REGISTRY OVERVIEW

Dr. Daniel Green, CMS

Measure Requirements

- QCDRs may utilize MIPS quality measures specified for QCDR reporting.
    - Measure Specifications provide a description of each measure in MIPS. They provide a blueprint to successful participation by outlining each element of a measure.
    - Measure specifications for 2017 MIPS QCDR reporting can be found on the Resource Library page of the QPP website or at the following direct link Quality Measure Specifications

- QCDRs must support:

    - at least 6 individual measures; AND

    - at least 1 outcome measure; OR if an outcome measures is not available, use at least 1 other high-priority measure.

    OR

    - a specialty measure set

Measure Requirements

- QCDR may also host up to 30 of their own "non-MIPS" measures, known as QCDR measures, that are approved by CMS for QCDR reporting.

- A QCDR measure includes:
  - A measure that isn't contained in the annual list of Quality Payment Program measures for the applicable performance period.
  - A measure that may be in the annual list of Quality Payment Program measures but has substantive differences in the denominator of the measure or the manner it's collected by the QCDR.
  - The CAHPS for MIPS survey, which can only be submitted using a CMS-approved survey vendor.

QCDR Measures

- QCDR measures must be clinically relevant, harmonized, aligned among all public and private payers, and minimally burdensome to report.
  - Please know that CMS believes that MIPS must ensure that the measures selected for the program reflect the best available science, and that may require retiring or revising measures so that they reflect the latest clinical guidelines and align with the MIPS program. Measures that have high performance rates or lack a performance gap in clinical care, do not provide meaningful measurement or benefit to the patient or clinician.

QCDR Measure Consideration

- Measures that are not duplicative of an existing or proposed measure.

- Measures that are beyond the measure concept phase of development, at a minimum.

- Measures that include a data submission method beyond claims-based data submission.

- Measures that are outcome-based rather than clinical process measures.

- Measures that address patient safety and adverse events.

- Measures that identify appropriate use of diagnosis and therapeutics.

- Measures that address the domain for care coordination.

- Measures that address the domain for patient and caregiver experience.

- Measures that address efficiency, cost and utilization of healthcare resources.

- Measures that address a performance gap or measurement gap.

QCDR Measures

- Raising the bar - PQRS was pay for reporting and MIPS is pay for performance.
  - Also applies to future program years of MIPS.

- Held to a higher standard, as QCDRs move to submit data for all performance categories of the program.

- We recommend that QCDRs utilize the Measure Development Plan and CMS Blueprint when developing and self-nominating QCDR measures.
  - Retire measures that are low bar, topped out, etc.
  - Address one or more of the six National Quality Strategy (NQS) priorities.

- Should meet the same standards as the QPP measures.

- Please note that QCDR measures that are not approved for QPP may be collected for internal reporting purposes.

QCDR Measures - Harmonization

- Proposed QCDR measures that were similar were requested to be harmonized.
  - If minor differences were identified, the QCDRs were asked to harmonize for 2017.
  - If major differences were identified, the measure is Provisionally Approved for 2017 and the QCDRs were asked to harmonize for 2018.
    - Measure will likely be rejected for 2018, if it is not harmonized.

- Measure harmonization between QCDRs provides eligible clinicians a bigger cohort for performance scoring and benchmarking

- Collaboration between QCDRs with similar measures is encouraged

- QCDRs must decide who (which QCDR) would retain the measure as the measure owner and perform the required measure maintenance as needed

- Please note that harmonized measures must be updated to align with the measure owner's measure specifications for each performance period. In addition, permission to use another QCDR's measure should be obtained by the time a QCDR self-nominates for each performance period.

SUBMISSION OVERVIEW

Dr. Daniel Green, CMS

QPP Year 1 Submission Modalities

Legacy Methods (Still Supported)

- Manual file upload in QRDA-III format

- Manual attestation

- Web Interface/GPRO/Beneficiary Sampling

- Claims-based Submission

Preferred Method

- Application Programming Interface (API) where data is exchanged between clinician systems, such as a Registry, and CMS without manual intervention

QPP Changes for Registries

Current State

- QCDR submits performance data to CMS on behalf of clinician or group by manually uploading QCDR XML or QRDA-III data file

QPP Year 1 2017

- QCDR must update workflows to support QPP measures and submission methods

- QCDR XML format no longer supported

- *Preferred method:* QCDR integrates directly with CMS via an API and passes data in QPP data format or QRDA-III format

- *Alternate method:* QCDR generates an XML or JSON file in QPP data format and submits to CMS via manual file upload on the QPP website

Registry XML vs. QPP Data Format

The new QPP Data Format will replace the Registry and QCDR XML formats for QPP Program Year 1/Transition Year (2017)

Why CMS is Changing Formats

- The existing Registry and QCDR XML formats did not support the QPP ACI and IA measures categories and would have had to change eventually to support them

- CMS was introducing a new way for Qualified Registries and QCDRs to submit via API rather than XML file upload and needed a data format that would work for both modalities

Benefits of New Format

The new QPP Data Format offers several benefits for Registries and QCDRs:

- Closely similar to existing Registry and QCDR XML formats

- Can be used for both file upload and API submissions via JSON or XML

- Includes the QPP ACI and IA measures categories in addition to Quality

What is an API?

- <u>A</u>pplication <u>P</u>rogramming <u>I</u>nterface
- Way for software applications to exchange data in an automated way

Benefits of API Based Interactions

Efficiency & Security

- **Eliminate** the **burden and risk** of manually moving data between systems

- **Reduce** the likelihood of **data errors**

- **Increase transactional velocity**

- **Decrease dependency** on intermediaries

Transparency

- **Real-time, descriptive feedback** enables clinicians to know where they stand with regard to their submission and their performance, as well as correct errors or improve performance

- **Eliminate need** for third parties **to reverse engineer** CMS scoring logic, leading to more consistent, realistic expectations about performance

Value

- Enable **one application change without** requiring **the other** to change

- Allow Registries, EHRs, QCDRs and other industry partners to **incorporate QPP Submissions functionality into** their **products**

QPP APIs

There will be two QPP APIs that developers can use to submit QPP performance data to CMS through direct software interaction, instead of manually:

Submissions API

- Submit data as a single file or a set of smaller files throughout the reporting period, using QRDA-III or a new, streamlined QPP data format

- Submit, update or delete ACI, IA and quality measures data during the reporting period

- Receive feedback on the content and accuracy of a submission

- Receive the preliminary score for a submission, based on the finalized policy

CMS Web Interface API

- If you are registered for the CMS Web Interface, download your group's beneficiary sample, modify it and submit it to the CMS Web Interface

- Receive feedback on the content and accuracy of a submission

- Receive a real-time composite score for a submission*

*Composite scores provided at the time of submission reflect all measure categories (Advancing Care Information (ACI), Improvement Activities (IA), and quality) submitted to date. These scores do not represent a guarantee of the final score.

API Timeline

Today

- Developer documentation - https://cmsgov.github.io/qpp-submissions-docs/

- Submissions API specification - https://cmsgov.github.io/qpp-submissions-docs/schemas

- Google Group where developers can interact with one another to ask questions, find answers and share experiences https://groups.google.com/forum/

- Developer sandbox where you can submit de-identified data in QPP data format for any of the 15 ACI measures, 92 IA measures, and/or 271 Quality measures, then get feedback and scoring - https://qpp-submissions-sandbox.navapbc.com/

Summer 2017

- Updated developer documentation

- Finalized Submissions API specification

- Finalized QPP data format specification

- Updated developer sandbox with the following additional functionality:
  - Ability to create a submissions using real TINs and NPIs

QPP MEASURE DEVELOPMENT FUNDING OPPORTUNITY

Dr. Daniel Green, CMS

MACRA Funding Opportunity: Measure Development for the Quality Payment Program

- CMS has announced its intention to provide funding assistance specifically for entities, external to CMS and other federal agencies, with working knowledge in quality measure development. The focus of these funds are to develop, improve, update or expand quality measures for use in the Quality Payment Program under the Merit-based Incentive Payment System (MIPS) and/or Advanced Alternative Payment Models (APMs). These external entities provide the needed medical specialty and patient perspectives to lead or support CMS measure development priorities.

- For more information and to see the Forecast of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program, search for CFDA # 93.986 on Grants.Gov.

Danielle A. Lloyd, MPH
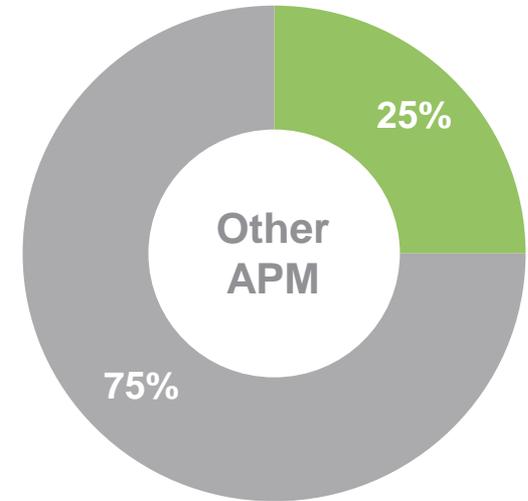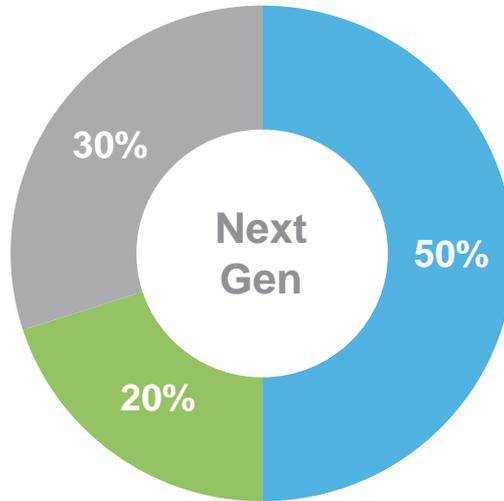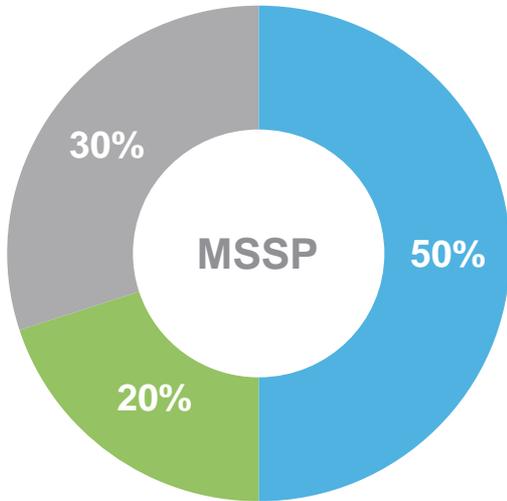**Vice President, Policy & Advocacy**
Deputy Director DC Office
Premier, Inc.
202-879-8002
Danielle_Lloyd@premierinc.com

MIPS: APM Scoring Standard

MSSP — 50% / 30% / 20%
Next Gen — 50% / 30% / 20%
Other APM — 25% / 75%

■ **Quality** — Measures reported by APM

Web Interface measures: 2018: 14 measures, 4 receive a bonus point • 2017: 11 measures

■ **Cost** — Not assessed

■ **Advancing care information** — Average of individual clinicians submitting as individuals or groups
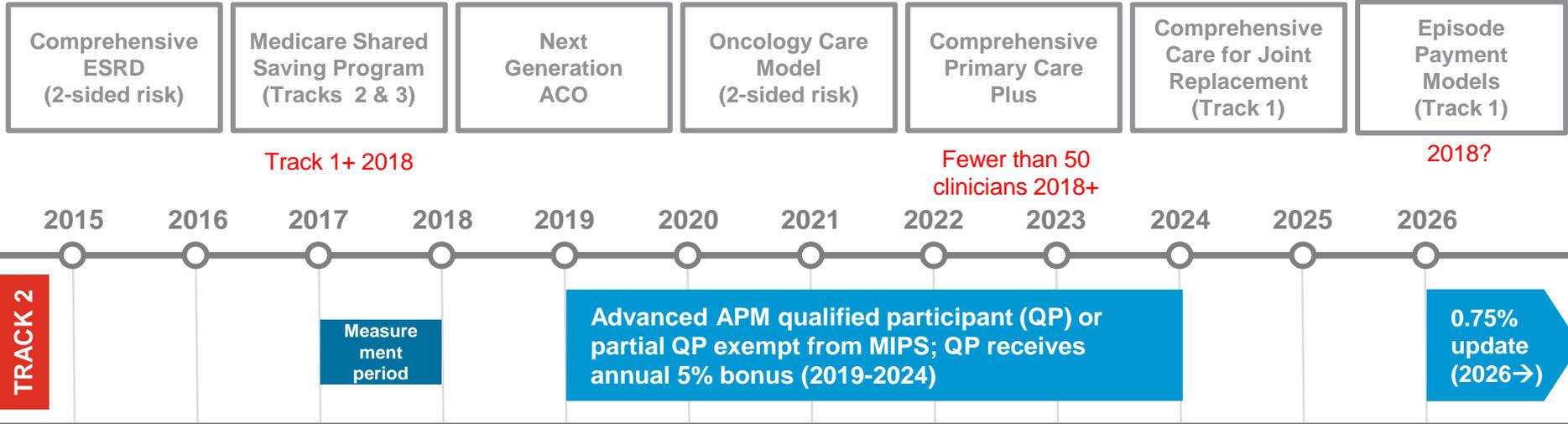
MSSP: Weighted average of score for TINs

■ **Improvement activities** — Automatically receive half of the points

Models awarded full points: Shared Savings, Next Gen, Comprehensive ESRD Care (all arrangements), Oncology Care Model (all arrangements), CPC+

5% Bonus for Advanced APMs

Advanced Alternative Payment Models (APM) as proposed:

Comprehensive ESRD (2-sided risk)	Medicare Shared Saving Program (Tracks 2 & 3)	Next Generation ACO	Oncology Care Model (2-sided risk)	Comprehensive Primary Care Plus	Comprehensive Care for Joint Replacement (Track 1)	Episode Payment Models (Track 1)

Track 1+ 2018

Fewer than 50 clinicians 2018+

2018?

2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026

TRACK 2

Measurement period

Advanced APM qualified participant (QP) or partial QP exempt from MIPS; QP receives annual 5% bonus (2019-2024)

0.75% update (2026→)

Advanced APM Entities Must:

1. Use certified EHR technology,

2. Pay based on MIPS comparable quality measures, *and*

3. Bear more than "nominal" financial risk for losses.

Inclusion in Advanced APMs triggers exclusion from MIPS.

Threshold of payments in an Advanced APM to reach QP status

2019-20	Medicare only	**25%**	Or, 20% beneficiary count
2021-22	Medicare* and all-payer	**50%**	Or, 35%
2023 +	Medicare* and all-payer	**75%**	Or, 50%

- Total payments exclude payments made by the Secretaries of Defense/Veterans Affairs and Medicaid payments in states without medical home programs or Medicaid APMs.

* Minimum of 25% of Medicare payments must be in APM in all years, unless partial qualifying with no 5% bonus and a choice of MIPS

Advanced APMs: Reporting

Model	Reporting Method
Comprehensive ESRD (2-sided Risk)	**CROWNWeb, NHSN, Survey, Claims**
Medicare Shared Savings Program (1+, 2, 3)	**CMS Web Interface, CG CAHPS**
Next Generation ACO	
Oncology Care Model (2-sided Risk)	**Claims, CMS registry, practice reported to other payers**
Comprehensive Primary Care Plus	**eCQMs via CPC+ attestation portal or QRDAIII**
Comprehensive Care for Joint Replacement	**Claims, HCAHPS, eCQMs**
Episode-Based Payment Models	

- Raising the exclusions bar would result in fewer participants than anticipated
- Facilities-based reporting would result in fewer participants using registries than anticipated
- Virtual groups could bring in solo/small practices
- Low bar for avoiding penalty will leave less $ for high performers
- Registry provides pathway to bonus points (end to end reporting)
- Lack of benchmark for new QCDR measures prevents max score
- Registries cannot submit WI measures
- Registries can differentiate themselves with quality improvement (not just submission) over claims and WI
- No role for private registries under existing AAPMs, but may play a role in upcoming specialty AAPMs from PTAC process

21st Century Cures Act

Became law December 13, 2016 with the intention to accelerate "discovery, development and delivery" of medical therapies by encouraging biomedical research investment, facilitating innovation review and approval processes, and continuing to invest in and modernize the delivery of health care.
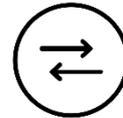
- Increases NIH funding to aid: Precision Medicine Initiative, BRAIN Initiative, cancer research, regenerative medicine
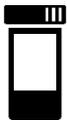
- Implements mental health reform

- Funds state grants for opioid initiatives

- Reduces administrative burden for researchers and physicians

- Enhances rigor/ reproducibility of scientific research

- Adds penalties of up to $1 million per violation for blocking information

- Facilitates collaborative research and data sharing

- Facilitates use of and access to electronic health records

- Expedites the FDA drug approval process: allows use of "real world data" and "qualified data summaries

- Improves pediatric clinical study

Cures makes it easier for providers under MIPS to report to clinical registries

MIPS eligible providers who report using certified EHRs will satisfy the clinical quality measure reporting requirement

A close look: Health IT gets an upgrade
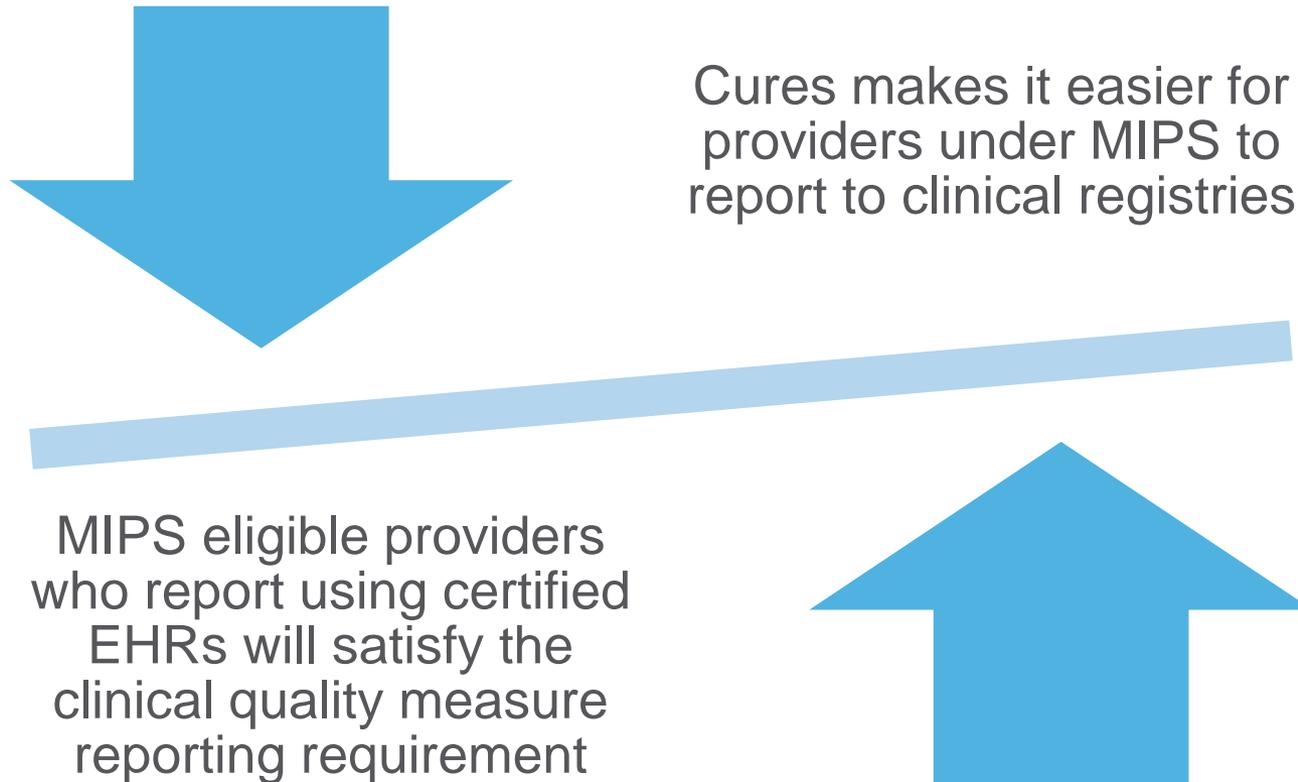
Interoperability

- Prohibits HIT vendors/providers from data blocking
- Requires better communication across vendors
- Requires Certified HIT to be able to transmit data to and accept from clinical registries
- Extends confidentiality protections for reporting/ analyzing patient safety info related to HIT use.
- Creates the HIT Advisory Committee

EHR Reporting

- Eases EHR reporting efforts, in part by allowing doctors to delegate some reporting to non-physicians
- Requires EHR certification based on a platform's usability and interoperability

Information Transfers

- Requires certified EHR to be able to transmit data to and from clinical data registries
- Encourages providers, health information networks and other stakeholders to make health data more accessible to patients

A close look: Health IT gets an upgrade

Provider Directory

- HHS is required to establish a digital contact directory to encourage the electronic exchange of information
- Must include all health professionals, health facilities and others to provide clearer, easier to use index for the transfer of information

Patient Matching

- Requires GAO to review policies and activities at ONC and other relevant stakeholders to ensure appropriate patient matching to protect patient privacy and security within 2 years of enactment

Patient Access

- GAO study on patient access to their own protected health information, including barriers to such patient access and complications or difficulties providers experience in providing access to patients
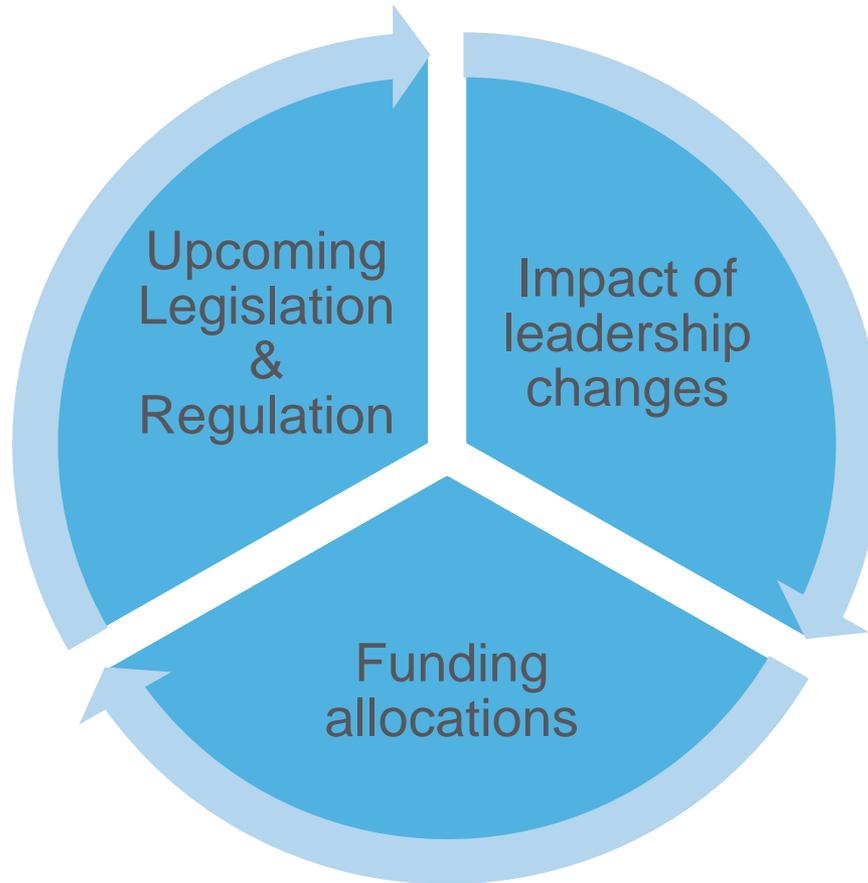
Discussion

Discussants

Dr. Dan Green, MD, FACOG
Medical Officer, Office of Clinical Standards and Quality
Centers for Medicare and Medicaid Services

Danielle A. Lloyd, MPH
Vice President, Policy and Advocacy
Premier, Inc.

Aisha T. Pittman, MPH
Senior Director, Quality Policy
Premier, Inc.

Moderator

Dr. Kathleen Hewitt, DNP, CPHQ, AACC
Associate Vice President,
Registries and Quality Initiatives
American College of Cardiology

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Thank you!

For questions or further information please contact:

Chrystal Price
Program Manager, Registry Programs
chrystal.price@thepcpi.org
312-224-6068

thepcpi.org

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