

The Office of the National Coordinator for
Health Information Technology

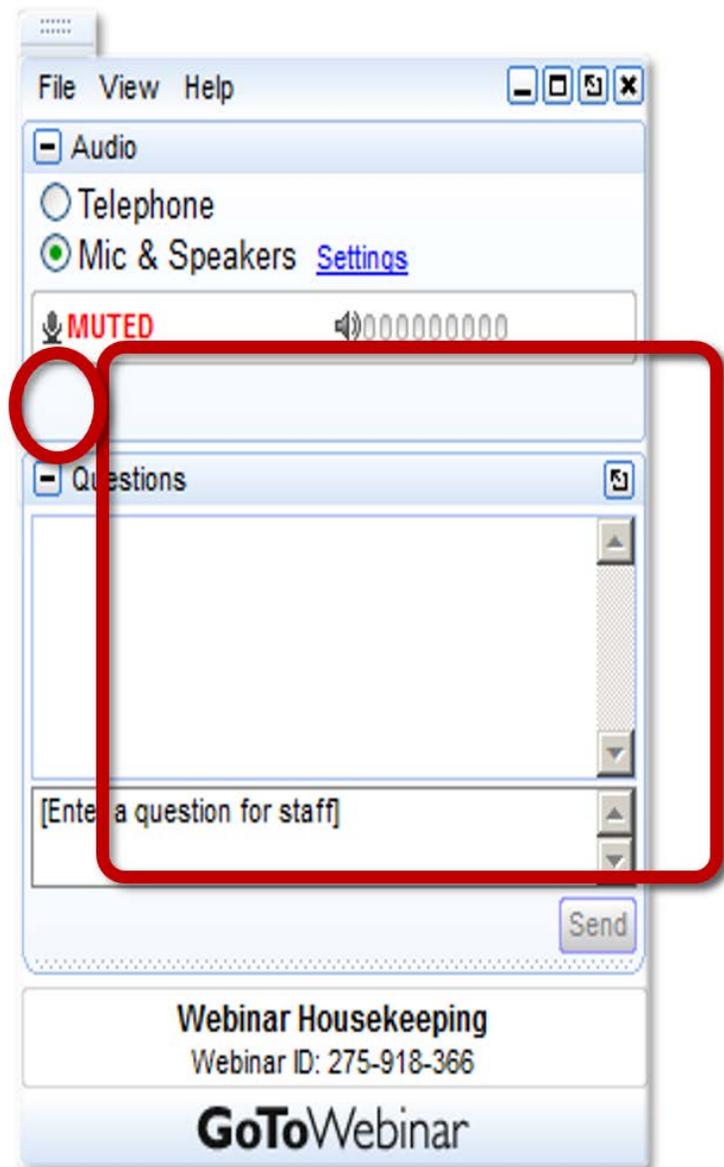


Joint Public Health Forum & CDC Nationwide

Webinar

July 20, 2017

Putting the **I** in Health **IT**
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- Please raise your hand to be unmuted for verbal questions.

Disclaimer

- **Medicare Program; CY 2018 Updates to the Quality Payment Program**, proposed rule was published by Centers for Medicare & Medicaid Services (CMS) in the federal register on June 30, 2017 and is currently open for public review and comments. Hence, this presentation is based on the proposed rule and the presenters may or may not be able to answer all questions related to this proposed rule, as per OMB recommendations and best practices applicable to this proposed rule, when open for public comment.
- Members of the public in general and the public health community in specific are requested to review the proposed rule and submit their questions and comments to CMS, to participate in the Government decision-making.

Medicare Program; CY 2018 Updates to the Quality Payment Program (Proposed Rule)

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Federal Rules & Public Health Reporting Requirements : At-a-glance*

	Prior Final Rules for All Providers			Proposed Rules for All Providers (retroactive to 2017 and 2018)	
Federal rule	EHR Incentive Program/Stage 3 Meaningful Use	MACRA, Quality Payment Program (MIPS)	OPPS Rule, Medicare Hospitals (and dual-eligible hospitals)	IPPS Proposed Rule for 2018 (Medicaid and Medicare Eligible Hospitals and Medicaid EPs) Comment period closed: Final Rule must be effective prior to October 1	QPP Proposed Rule for 2018 (Medicare Eligible Clinicians) Comment period closes August 21st
Eligible provider types	Medicaid clinicians and hospitals who bill either Medicare or Medicaid	Medicare part B clinicians	Hospitals that attest to Medicare EHR incentive program or both Medicaid and Medicare (dual-eligible)	Medicare and Medicaid EH and Medicaid EP	Medicare eligible clinicians
How rule impacts meaningful use public health reporting	No more required vs. optional public health reporting options but eligible providers must choose a set number (2 for EPs and 4 for EHs and CAHs) of measures from all that are available (from public health agency) *see OPPS rule column for note on number of measures for Medicare and dual-eligible hospitals	Reduces the overall meaningful use reporting requirements including making all public health reporting optional. The options are the same as in meaningful use. All of the public health measures are yes/no vs. numerator/denominator	Revises some MU requirements for hospitals only. Resets number of required public health options to report on at 3 for EH and CAH.	No more required vs. optional public health reporting options but eligible providers must choose a set number (2 for EPs and 3 for EHs and CAHs) of measures from all that are available (from public health agency) *see OPPS rule column for note on number of measures for Medicare and dual-eligible hospitals	Revise requirements for Eligible Clinicians (previously referred to as Eligible Clinicians)

*Created by the Meaningful Use Public Health Reporting Requirements Task Force

Medicare Program; CY 2018 Updates to the Quality Payment Program

- **Medicare Program; CY 2018 Updates to the Quality Payment Program**
- **AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.
- **ACTION:** Proposed rule.
- **SUMMARY:** The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- established the Quality Payment Program for eligible clinicians. Under the Quality Payment
- Program, eligible clinicians can participate via one of two tracks: Advanced Alternative
- Payment Models (APMs); or the Merit-based Incentive Payment System (MIPS). CMS began
- implementing the Quality Payment Program through rulemaking for calendar year (CY) 2017.
- This rule provides proposed updates for the second and future years of the Quality Payment Program.
- **Public Comments Deadline:** August 21, 2017, no later than 5 p.m.

Medicare Program; CY 2018 Updates to the Quality Payment Program

The Quality Payment Program aims to-

- (1) support care improvement by focusing on better outcomes for patients, decreased clinician burden, and preservation of independent clinical practice;
- (2) promote adoption of APMs that align incentives for high-quality, low-cost care across healthcare stakeholders; and
- (3) advance existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

Medicare Program; CY 2018 Updates to the Quality Payment Program

CMS previously finalized the transition year Quality Payment Program policies in the CY 2017 Quality Payment Program final rule. In that final rule, CMS implemented policies to improve-

- Physician and other clinician payments by changing the way Medicare incorporates quality measurement into payments and by developing new policies to address and incentivize participation in APMs.
- The final rule established the Quality Payment Program and its two interrelated pathways:
 - Advanced Alternate Payment Models (Advanced APMs)
 - The Merit-Based Incentive Payment System (MIPS)

Medicare Program; CY 2018 Updates to the Quality Payment Program

- In this proposed rule, CMS is building and improving Quality Payment Program policies designed to integrate easily across clinical practices during the second and future years of implementation.
- In this proposed rule, CMS has also addressed elements of Medicare Access and CHIP Reauthorization Act of 2015 that were not included in the first year of the program, including virtual groups, facility-based measurement, and improvement scoring.

Medicare Program; CY 2018 Updates to the Quality Payment Program

- CMS also included proposals to continue implementing elements of MACRA that do not take effect in the first or second year of the Quality Payment Program, including policies related to the All-Payer Combination Option for identifying QPs and assessing eligible clinicians' participation in Other Payer Advanced APMs.
- To provide unity and consistency across the two paths of the Quality Payment Program, MIPS and APMs, in this proposed rule CMS has referred to the second year of the program as "Quality Payment Program Year 2."

Medicare Program; CY 2018 Updates to the Quality Payment Program

Scoring

- CMS has established at §414.1380(b)(4) that the score for the advancing care information performance category would be comprised of-
 - Base score,
 - Performance score, and
 - Bonus points for reporting on certain measures and activities.

Medicare Program; CY 2018 Updates to the Quality Payment Program (Performance Score)

CMS is proposing to modify the scoring of the Public Health and Clinical Data Registry Reporting objective beginning with the performance period in CY 2018.

- It is proposed if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score.
- If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, Then CMS is proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting.

Medicare Program; CY 2018 Updates to the Quality Payment Program (Performance Score)

- By proposing to expand the options for fulfilling the Public Health and Clinical Data Registry Reporting and the Public Health Reporting objectives, CMS believes that we are adding flexibility so that additional MIPS eligible clinicians can successfully fulfill this objective and earn 10 percentage points in the performance score.
- CMS is not proposing to change the maximum performance score that a MIPS eligible clinician can earn; it remains at 90 percent.
- CMS is inviting public comment on these proposals.

Medicare Program; CY 2018 Updates to the Quality Payment Program (Bonus Score)

- In the CY 2017 Quality Payment Program final rule (81 FR 77220 through 77226), for the Public Health and Clinical Data Registry Reporting objective and the Public Health Reporting objective, CMS finalized that MIPS eligible clinicians who report to one or more public health agencies or clinical data registries beyond the Immunization Registry Reporting Measure will earn a bonus score of 5 percentage points in the advancing care information performance category.
- In this proposed rule, CMS is proposing that a MIPS eligible clinician may earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/or registries to which the MIPS eligible clinician reports to earn a performance score.

For example, if a MIPS eligible clinician reports to a public health agency and a clinical data registry for the performance score, they could earn the bonus score of 5 percentage points by reporting to a different agency or registry that the clinician did not identify for purposes of the performance score.
- In section II.C.6.f.(6)(b) of this proposed rule, CMS is proposing to allow MIPS eligible clinicians to report using the 2018 Advancing Care Information Transition Objectives and Measures for this bonus in 2018.

Medicare Program: CY2018 CEHRT (Bonus Score)

To encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products which better support interoperability across the care continuum, CMS is proposing to offer a bonus of 10 percentage points under the advancing care information performance category for MIPS eligible clinicians who report the Advancing Care Information Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT

**TABLE 7: Page (30067)-2018 Performance Period Advancing Care Information Performance Category
Scoring Methodology
Advancing Care Information Objectives and Measures**

2018 Advancing Care Information Objective	2018 Advancing Care Information Measure*	Required/ Not Required for Base Score (50%)	Performance Score (up to 90%)	Reporting Requirement
Protect Patient Health Information	Security Risk Analysis	Required	0	Yes/No Statement
Electronic Prescribing	c-Prescribing	Required	0	Numerator/ Denominator
Patient Electronic Access	Provide Patient Access	Required	Up to 10%	Numerator/ Denominator
	Patient-Specific Education	Not Required	Up to 10%	Numerator/ Denominator
Coordination of Care Through Patient Engagement	View, Download, or Transmit (VDT)	Not Required	Up to 10%	Numerator/ Denominator
	Secure Messaging	Not Required	Up to 10%	Numerator/ Denominator
	Patient-Generated Health Data	Not Required	Up to 10%	Numerator/ Denominator
Health Information Exchange	Send a Summary of Care	Required	Up to 10%	Numerator/ Denominator
	Request/Accept Summary of Care	Required	Up to 10%	Numerator/ Denominator
	Clinical Information Reconciliation	Not Required	Up to 10%	Numerator/ Denominator
Public Health and Clinical Data Registry Reporting	Immunization Registry Reporting	Not Required	0 or 10%	Yes/No Statement
	Syndromic Surveillance Reporting	Not Required	0 or 5%*	Yes/No Statement
	Electronic Case Reporting	Not Required	0 or 5%*	Yes/No Statement
	Public Health Registry Reporting	Not Required	0 or 5%*	Yes/No Statement
	Clinical Data Registry Reporting	Not Required	0 or 5%*	Yes/No Statement
Bonus (up to 25%)				
Report to one or more additional public health agencies or clinical data registries beyond those identified for the performance score		5% bonus		Yes/No Statement
Report improvement activities using CEHRT		10% bonus		Yes/No Statement
Report using only 2015 Edition CEHRT		10% bonus		Based upon measures submitted

* A MIPS eligible clinician who cannot fulfill the Immunization Registry Reporting Measure may earn 5% for each public health agency or clinical data registry to which the clinician reports, up to a maximum of 10% under the performance score.

TABLE 8 (Page # 30070, Federal Register /Vol. 82, No. 125 / Friday, June 30, 2017 /QPP Proposed Rule): —
 ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND CERTIFICATION CRITERIA FOR 2014 AND
 2015 EDITIONS

TABLE 8—ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND CERTIFICATION CRITERIA FOR 2014 AND
 2015 EDITIONS

Objective	Measure	2015 Edition	2014 Edition
Protect Patient Health Information. Electronic Prescribing ..	Security Risk Analysis e-Prescribing	The requirements are a part of CEHRT specific to each certification criterion. § 170.315(b)(3) (Electronic Prescribing). § 170.315(a)(10) (Drug-Formulary and Preferred Drug List checks).	The requirements are included in the Base EHR Definition. § 170.314(b)(3) (Electronic Prescribing). § 170.314(a)(10) (Drug-Formulary and Preferred Drug List checks).
Patient Electronic Access.	Provide Patient Access.	§ 170.315(e)(1) (View, Download, and Transmit to 3rd Party). § 170.315(g)(7) (Application Access—Patient Selection). § 170.315(g)(8) (Application Access—Data Category Request). § 170.315(g)(9) (Application Access—All Data Request) The three criteria combined are the “API” certification criteria.	§ 170.314(e)(1) (View, Download, and Transmit to 3rd Party).
Patient Electronic Access. Coordination of Care Through Patient Engagement.	Patient Specific Education. View, Download, or Transmit (VDT).	§ 170.315(a)(13) (Patient-specific Education Resources). § 170.315(e)(1) (View, Download, and Transmit to 3rd Party). § 170.315(g)(7) (Application Access—Patient Selection). § 170.315(g)(8) (Application Access—Data Category Request). § 170.315(g)(9) (Application Access—All Data Request) The three criteria combined are the “API” certification criteria.	§ 170.314(a)(13) (Patient-specific Education Resources). § 170.314(e)(1) (View, Download, and Transmit to 3rd Party).
Coordination of Care Through Patient Engagement.	Secure Messaging	§ 170.315(e)(2) (Secure Messaging)	§ 170.314(e)(3) (Secure Messaging).

TABLE 8 (Page # 30070, Federal Register /Vol. 82, No. 125 / Friday, June 30, 2017 /QPP Proposed Rule): —
 ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND CERTIFICATION CRITERIA FOR 2014 AND
 2015 EDITIONS (Continued)

Coordination of Care Through Patient Engagement.	Patient-Generated Health Data.	§ 170.315(e)(3) (Patient Health Information Capture) Supports meeting the measure, but is NOT required to be used to meet the measure. The certification criterion is part of the CEHRT definition beginning in 2018.	N/A.
Health Information Exchange.	Send a Summary of Care.	§ 170.315(b)(1) (Transitions of Care)	§ 170.314(b)(2) (Transitions of Care-Create and Transmit Transition of Care/Referral Summaries or § 170.314(b)(8) (Optional—Transitions of Care).
Health Information Exchange.	Request/Accept Summary of Care.	§ 170.315(b)(1) (Transitions of Care)	§ 170.314(b)(1) (Transitions of Care-Receive, Display and Incorporate Transition of Care/Referral Summaries or § 170.314(b)(8) (Optional-Transitions of Care).
Health Information Exchange.	Clinical Information Reconciliation.	§ 170.315(b)(2) (Clinical Information Reconciliation and Incorporation).	§ 170.314(b)(4) (Clinical Information Reconciliation or § 170.314(b)(9) (Optional—Clinical Information Reconciliation and Incorporation).
Public Health and Clinical Data Registry Reporting.	Immunization Registry Reporting.	§ 170.315(f)(1) (Transmission to Immunization Registries).	N/A.
Public Health and Clinical Data Registry Reporting.	Syndromic Surveillance Reporting.	§ 170.315(f)(2) (Transmission to Public Health Agencies—Syndromic Surveillance) Urgent Care Setting Only.	§ 170.314(f)(3) (Transmission to Public Health Agencies—Syndromic Surveillance) or § 170.314(f)(7) (Optional-Ambulatory Setting Only-Transmission to Public Health Agencies—Syndromic Surveillance).
Public Health and Clinical Data Registry Reporting.	Electronic Case Reporting.	§ 170.315(f)(5) (Transmission to Public Health Agencies—Electronic Case Reporting).	N/A.



TABLE 8 (Page # 30071, Federal Register /Vol. 82, No. 125 / Friday, June 30, 2017 /QPP Proposed Rule): —
 ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND CERTIFICATION CRITERIA FOR 2014 AND
 2015 EDITIONS (Continued)

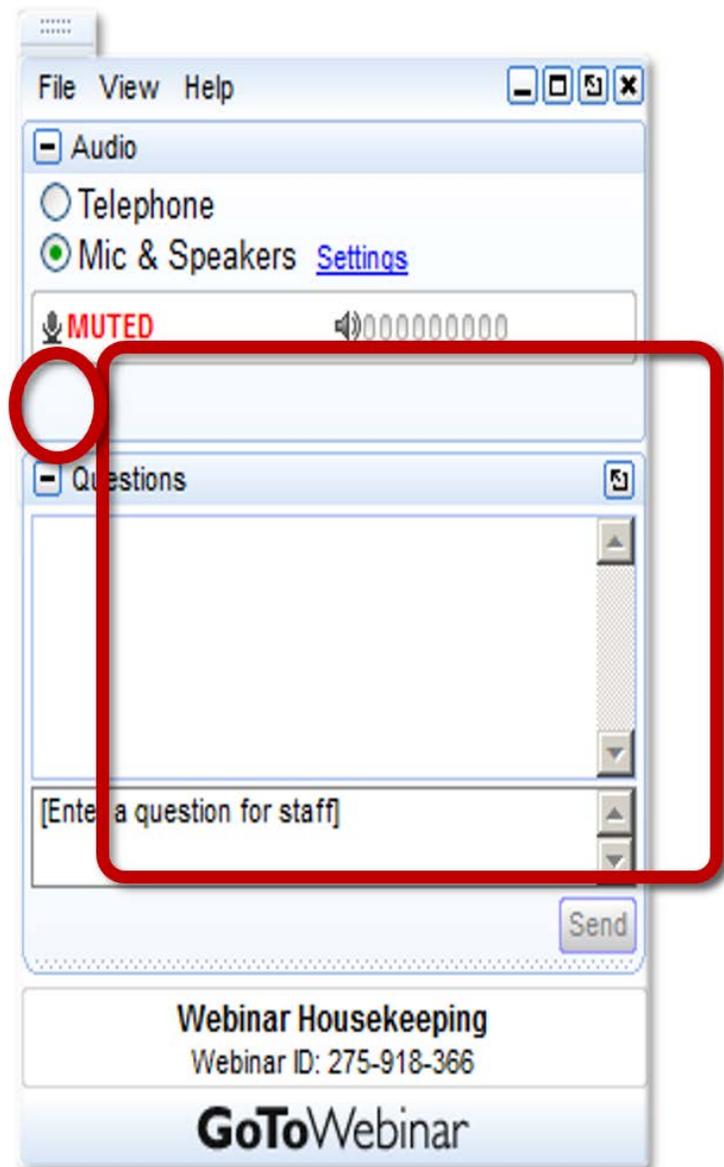
TABLE 8—ADVANCING CARE INFORMATION OBJECTIVES AND MEASURES AND CERTIFICATION CRITERIA FOR 2014 AND
 2015 EDITIONS—Continued



Objective	Measure	2015 Edition	2014 Edition
Public Health and Clinical Data Registry Reporting.	Public Health Registry Reporting.	EPs may choose one or more of the following: § 170.315(f)(4) (Transmission to Cancer Registries). § 170.315(f)(7) (Transmission to Public Health Agencies—Health Care Surveys).	§ 170.314(f)(5) (Optional—Ambulatory Setting Only—Cancer Case Information and § 170.314(f)(6) (Optional—Ambulatory Setting Only—Transmission to Cancer Registries).
Public Health and Clinical Data Registry Reporting.	Clinical Data Registry Reporting.	No 2015 Edition health IT certification criteria at this time.	N/A.

We are inviting public comment on these proposals.

(b) 2017 and 2018 Advancing Care Information Transition Objectives and Measures Specifications



Submit or Ask Questions

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