June CMS Quality Vendor Workgroup

June 23, 2016
12:00 PM EDT

Agenda

Agenda Item	Speaker
Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category	**Vidya Sellappan** *Division of Health Information Technology (DHIT), CMS*
Hospital Inpatient Quality Reporting (HIQR) Update	**Artrina Sturges** *On behalf of CMS*
Privacy and Security Update: Electronic Exchange of PHI for Treatment and Health Care Operations	**Peyton Isaac** *Office of the Chief Privacy Officer (OCPO), ONC*
HIPAA Access Guidance Update	**Deven McGraw** *Office for Civil Rights (OCR)*
Navigating the Electronic Clinical Quality Improvement (eCQI) Resource Center	**Edna Boone and Shanna Hartman** *On behalf of CMS*
2016 PQRS Electronic Reporting: Getting Started with GPRO	**Sophia Autrey** *Division of Electronic and Clinician Quality (DECQ), CMS*
Questions	

Merit-Based Incentive Payment System:

Advancing Care Information Performance Category

Vidya Sellappan, DHIT, CMS

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

KEY TOPICS:

1) The Quality Payment Program and HHS Secretary's Goals
2) What is the Quality Payment Program?
3) How do I submit comments on the proposed rule?
4) The Merit-based Incentive Payment System (MIPS)
5) The Advancing Care Information Performance Category
6) What are the next steps?

The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:
Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

30%

GOAL 2:
Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018

85%

STAKEHOLDERS:
Consumers | Businesses
Payers | Providers
State Partners
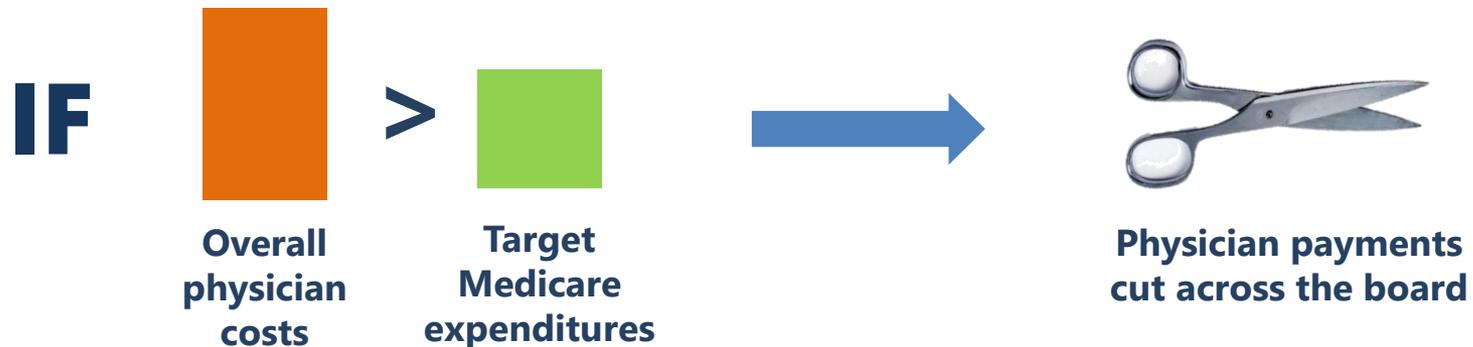
Set **internal goals** for HHS

Invite **private sector payers** to match or exceed HHS goals

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

IF [Overall physician costs] **>** [Target Medicare expenditures] → [Physician payments cut across the board]

Overall physician costs   **Target Medicare expenditures**   **Physician payments cut across the board**

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

INTRODUCING THE QUALITY PAYMENT PROGRAM

Quality Payment Program

✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS)	or	Advanced Alternative Payment Models (APMs)

✓ **First step to a fresh start**

✓ **We're listening and help is available**

✓ **A better, smarter Medicare for healthier people**

✓ **Pay for what works to create a Medicare that is enduring**

✓ **Health information needs to be open, flexible, and user-centric**

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting, refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
    - Regulations.gov
    - by regular mail
    - by express or overnight mail
    - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

MIPS: First Step to a Fresh Start

✓ **MIPS is a new program**

- • **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**

- • **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)	**Value-Based Payment Modifier (VM)**	**Medicare Electronic Health Records (EHR) Incentive Program**

MIPS: Major Provisions

- ✓ **Eligibility (participants and non-participants)**

- ✓ **Performance categories & scoring**

- ✓ **Data submission**

- ✓ **Performance period & payment adjustments**

Who Will Participate in MIPS?

Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.
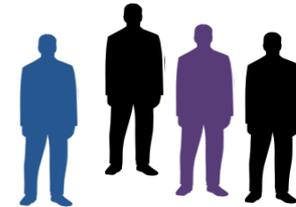
Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as
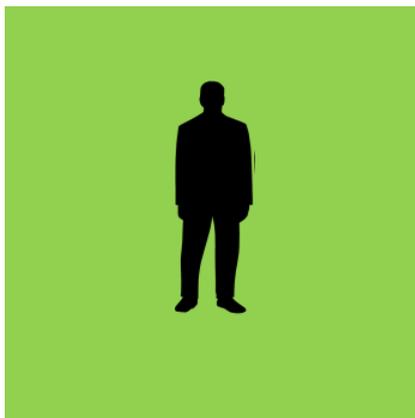
Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

FIRST year of Medicare Part B participation

Below low patient volume threshold

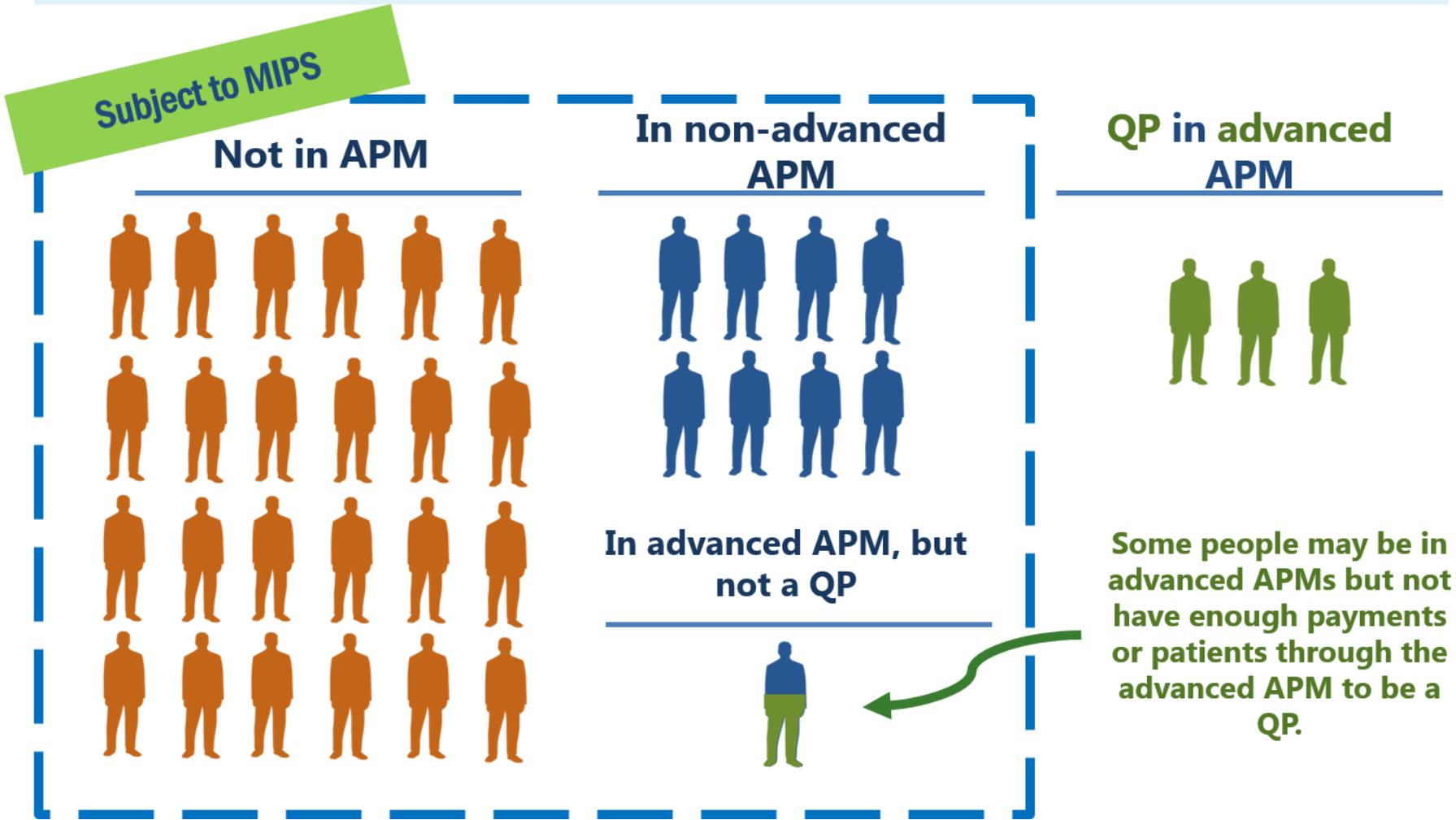**Certain participants in ADVANCED Alternative Payment Models**

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM

In non-advanced APM

QP in advanced APM

In advanced APM, but not a QP

Some people may be in advanced APMs but not have enough payments or patients through the advanced APM to be a QP.

Note: Figure not to scale.

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Or

Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Quality

Resource use

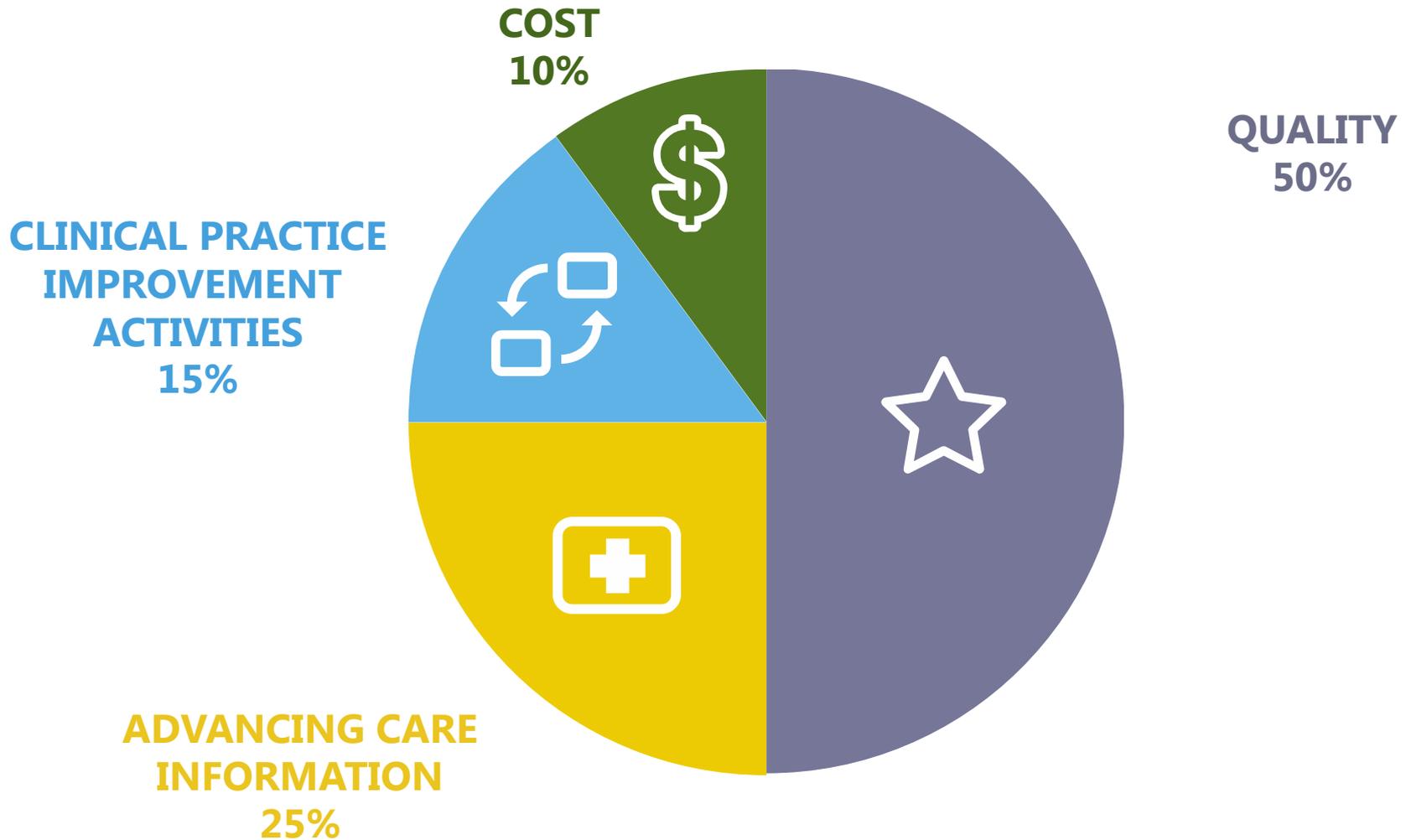**Clinical practice improvement activities**

Advancing care information

MIPS Composite Performance Score (CPS)

Year 1 Performance Category Weights for MIPS

COST
10%

QUALITY
50%

CLINICAL PRACTICE
IMPROVEMENT
ACTIVITIES
15%

ADVANCING CARE
INFORMATION
25%

PROPOSED RULE
MIPS: ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

Changes from EHR Incentive Program to Advancing Care Information

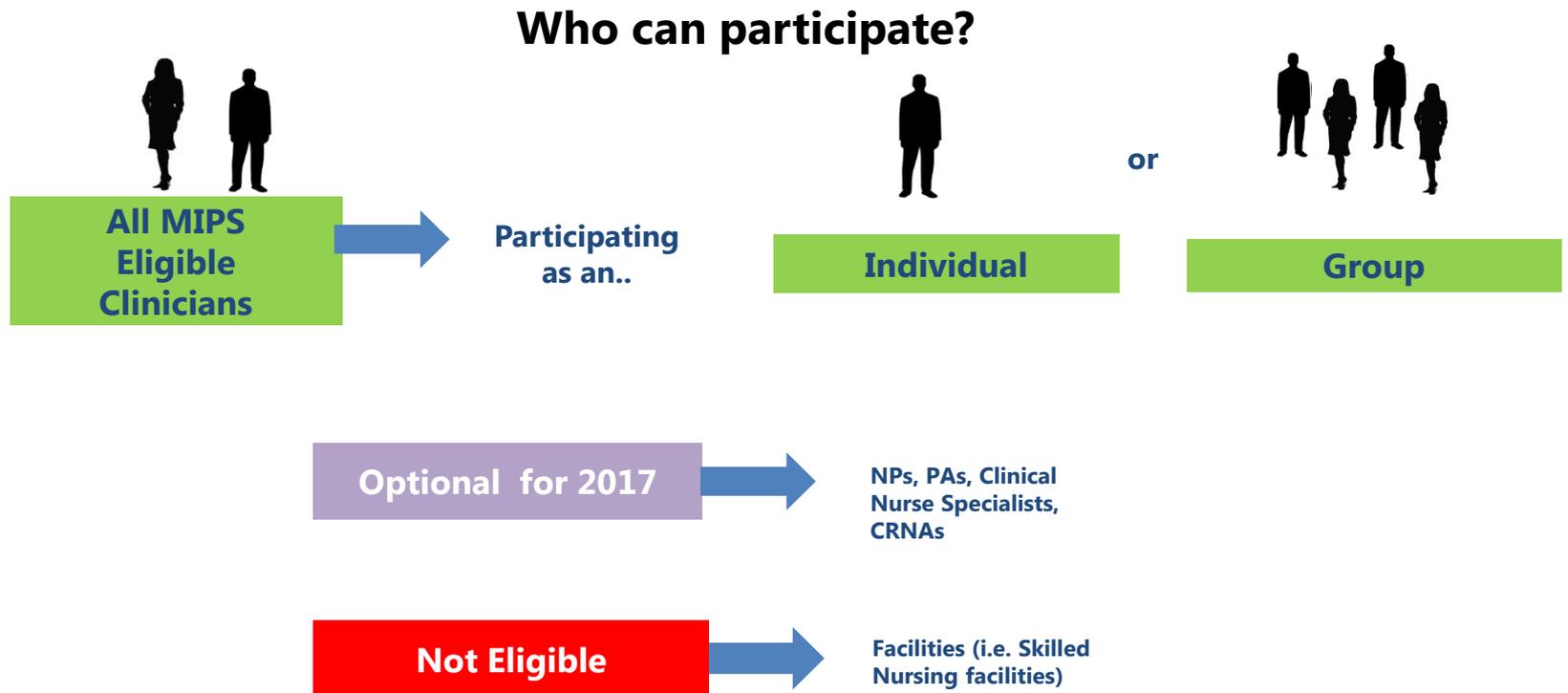| Past Requirements for the Medicare EHR Incentive Program	New Proposal for Advancing Care Information Category
One-size-fits-all – every objective reported and weighed equally	Customizable – clinicians can choose which categories to emphasize in their scoring
Requires across-the-board levels of achievement or "thresholds," regardless of practice or experience	Flexible. Allows for diverse reporting that matches clinician's practice and experience.
Measurement emphasizing process	Measurement emphasizing patient engagement and interoperability
Disjointed and redundant with other Medicare reporting programs	Aligned with other Medicare reporting programs. No need to report redundant quality measures.
No exemptions for reporting	Exemptions for reporting for clinicians in: • Advanced alternative payment models • First year with Medicare • Have low Medicare volumes

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :

Quality

Resource use

Clinical practice improvement activities

Advancing care information

MIPS Composite Performance Score (CPS)

* % weight of this **may decrease** as more users adopt EHR

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Who can participate?

All MIPS Eligible Clinicians → Participating as an..

Individual or **Group**

Optional for 2017 → NPs, PAs, Clinical Nurse Specialists, CRNAs

Not Eligible → Facilities (i.e. Skilled Nursing facilities)

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

BASE SCORE + **PERFORMANCE SCORE** + **BONUS POINT** = **COMPOSITE SCORE**

BASE SCORE	PERFORMANCE SCORE	BONUS POINT	COMPOSITE SCORE
Account for **50 points** of the total **Advancing Care Information Performance** Category Score	Account for **80 points** of the total **Advancing Care Information Performance** Category Score	Up to **1 point** of the total **Advancing Care Information Performance** Category Score	Earn 100 or more points and receive **FULL 25 points** in the **Advancing Care Information Category** of MIPS Composite Score

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 percentage points

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Base Score
Accounts for 50 percentage points of the total Advancing Care Information category score.

To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

THE PERFORMANCE SCORE
The performance score accounts for up to 80 percentage points towards the total Advancing Care Information category score

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

Patient Electronic Access

Coordination of Care Through Patient Engagement

Health Information Exchange

MIPS: Advancing Care Information Performance Category

Summary:

✓ **Scoring based on key measures of patient engagement and information exchange.**

✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**

✓ **Key Changes from Current Program (EHR Incentive):**

- **Dropped "all or nothing" threshold for measurement**
- **Removed redundant measures to alleviate reporting burden.**
- **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
- **Reduced the number of required public health registries to which clinicians must report**
- **Year 1 Weight: 25%**

PROPOSED RULE
MIPS COMPOSITE SCORE

PROPOSED RULE
MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of patient engagement and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all cost measures that can be attributed	10 percent

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

A single MIPS composite performance **score** will factor in performance in
4 weighted performance categories on a 0-100 point scale :

Quality

Resource use

Clinical practice improvement activities

Advancing care information

=

MIPS Composite Performance Score (CPS)

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

30

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

✓ **MIPS composite performance scoring method that accounts for:**

- **Weights of each performance category**

- **Exceptional performance factors**

- **Availability and applicability of measures for different categories of clinicians**

- **Group performance**

- **The special circumstances of small practices, practices located in rural areas, and non-patient- facing MIPS eligible clinicians**

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
⭐ **Quality**	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
➕ **Advancing care information**	25%	• Base score of 50 percentage points achieved by reporting at least one use case for each available measure • Performance score of up to 80 percentage points • Public Health Reporting bonus point • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
💲 **Resource Use**	10%	• Similar to quality

✓ Unified scoring system:
  1. Converts measures/activities to points
  2. Eligible Clinicians will know in advance what they need to do to achieve top performance
  3. Partial credit available

HOW DO I GET MY DATA TO CMS?
DATA SUBMISSION FOR MIPS
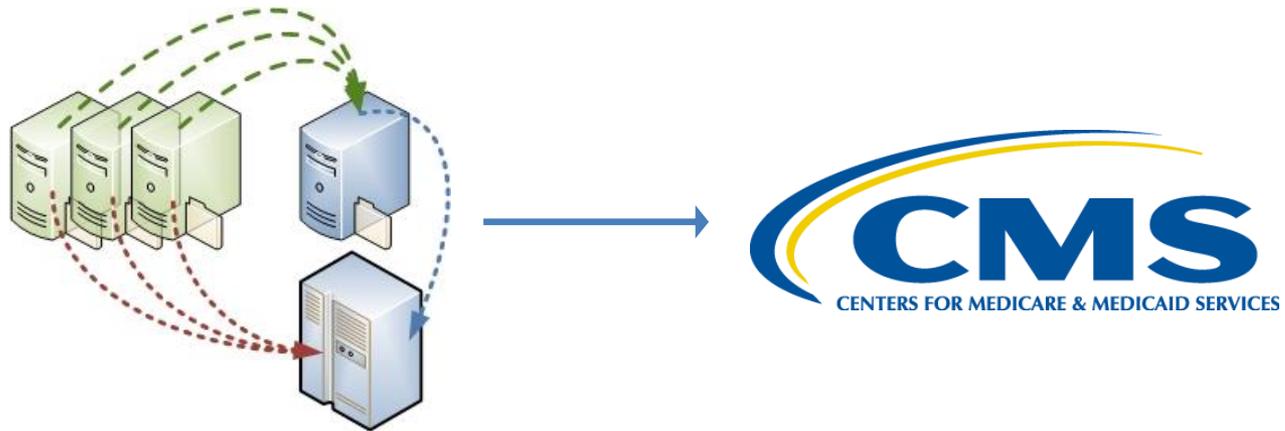
PROPOSED RULE
MIPS PERFORMANCE PERIOD & PAYMENT ADJUSTMENT

PROPOSED RULE
MIPS Performance Period
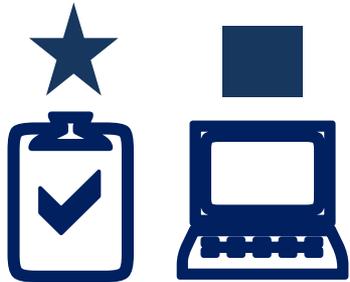
MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Period		**Payment Year**						

MIPS: Payment Adjustment

- ✓ **A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.**

- ✓ **A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.**

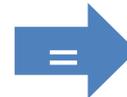- ✓ **A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

=

MIPS Composite Performance Score (CPS)

MIPS: Payment Adjustment

✓ **A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.**

✓ **An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an "additional performance threshold," defined as the 25th quartile of possible values above the CPS performance threshold.**
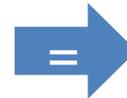
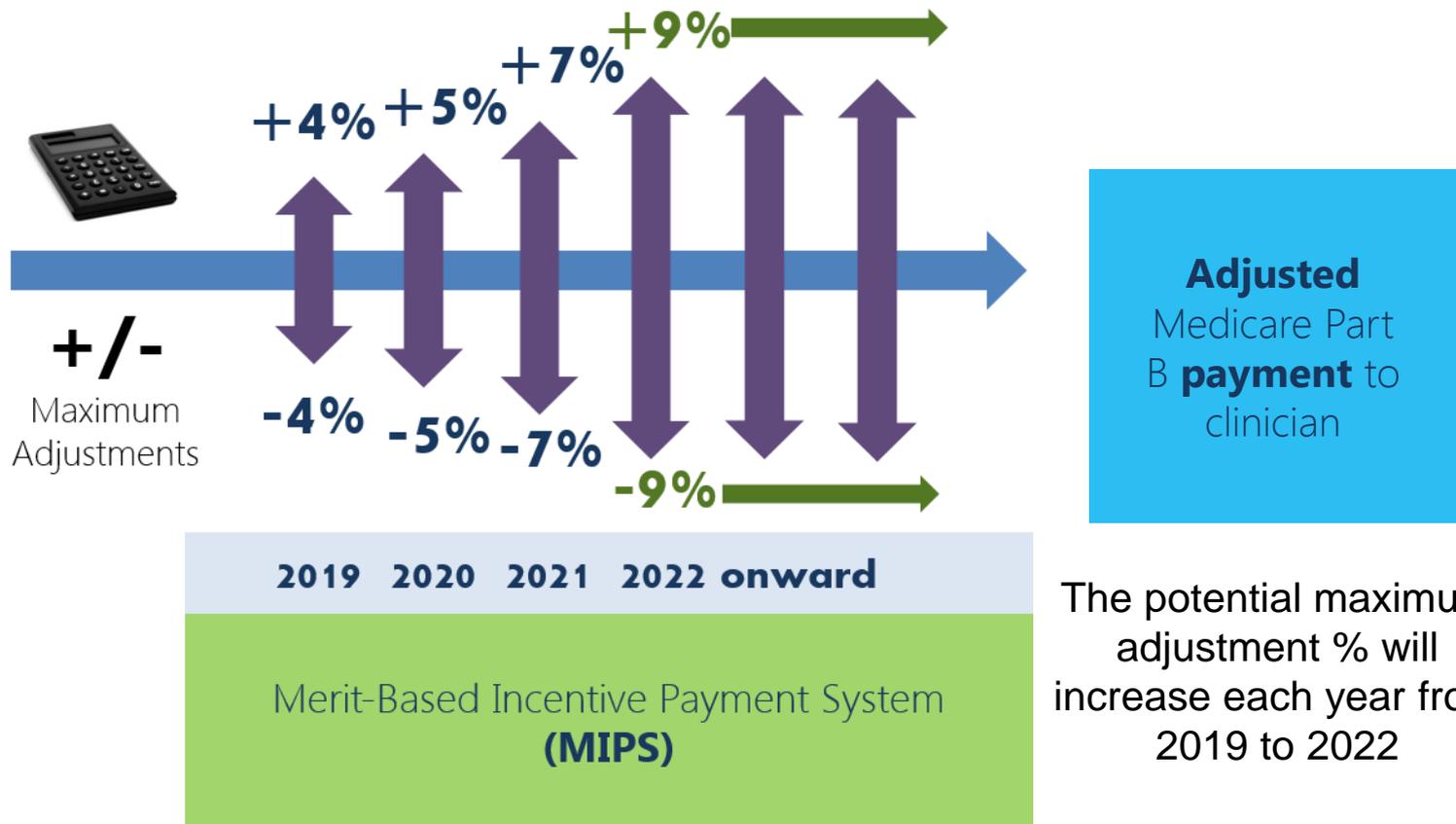**Quality** **Resource use** **Clinical practice improvement activities** **Advancing care information** = **MIPS Composite Performance Score (CPS)**

How much can MIPS adjust payments?

Based on a CPS, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.

+/- Maximum Adjustments

+4% +5% +7% +9%

-4% -5% -7% -9%

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System **(MIPS)**

Adjusted Medicare Part B **payment** to clinician

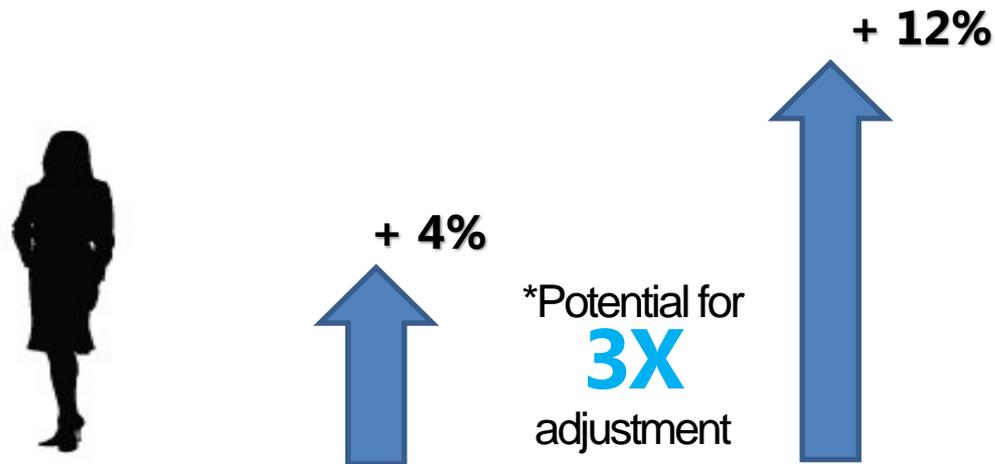The potential maximum adjustment % will increase each year from 2019 to 2022

How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

+4% +5% +7% +9%

-4% -5% -7% -9%

+/-
Maximum Adjustments

*Potential for
3X
adjustment

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System
(MIPS)
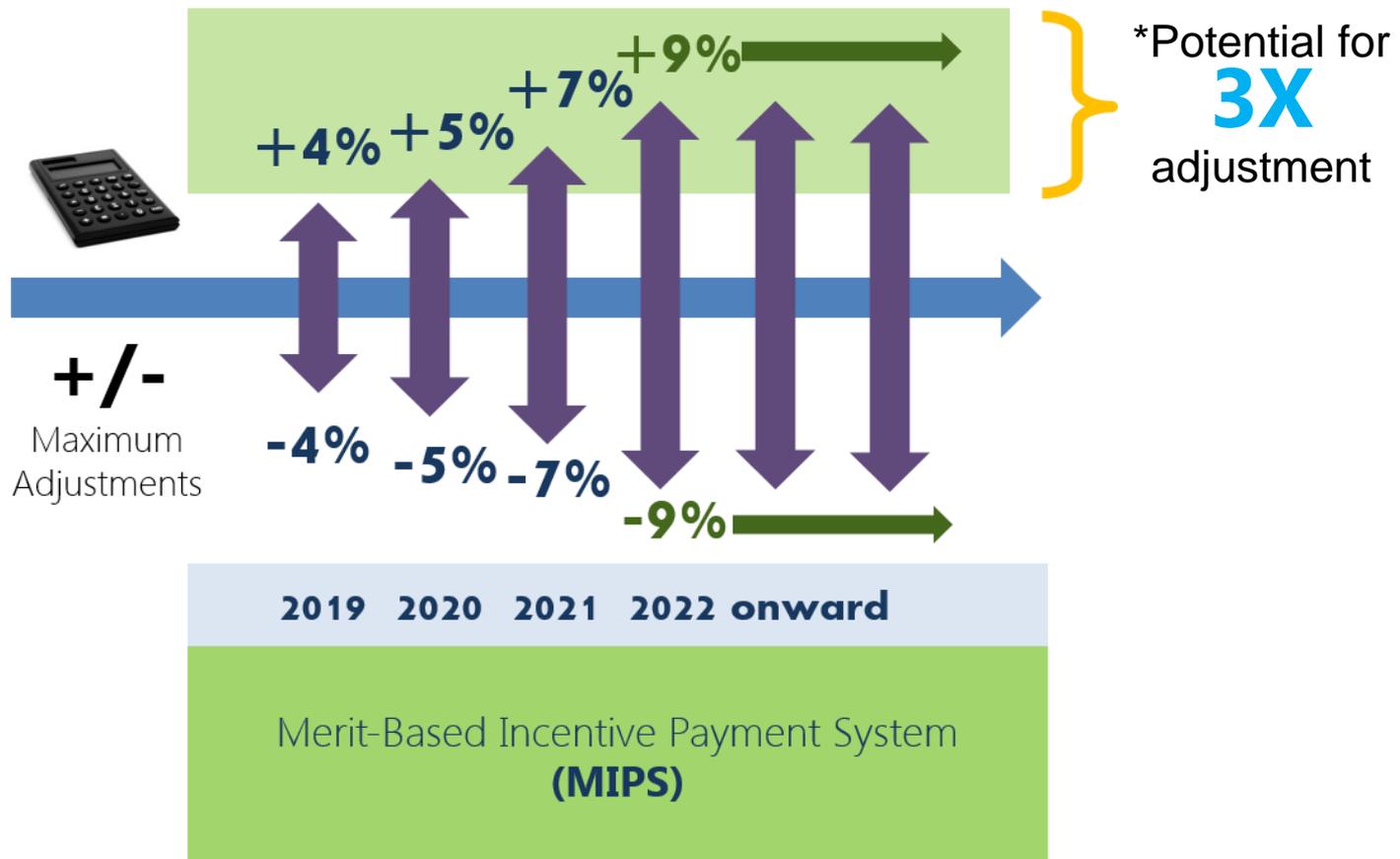
MIPS: Scaling Factor Example

+ 12%

+ 4%

*Potential for
3X
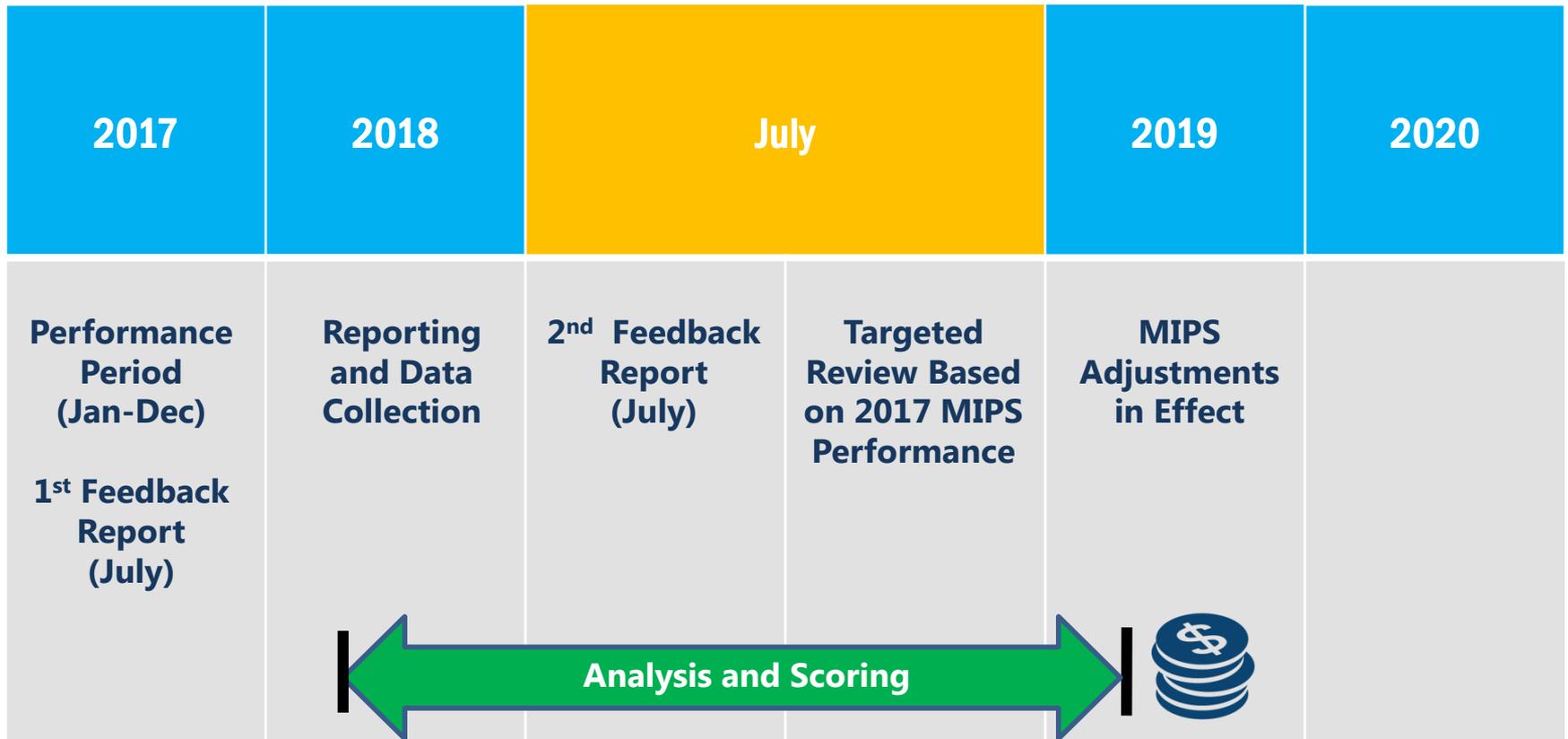adjustment

Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

PROPOSED RULE
MIPS Timeline

| 2017	2018	July		2019	2020
Performance Period (Jan-Dec) 1st Feedback Report (July)	Reporting and Data Collection	2nd Feedback Report (July)	Targeted Review Based on 2017 MIPS Performance	MIPS Adjustments in Effect	

Analysis and Scoring

HOW TO SUBMIT COMMENTS

To submit comments on the Medicare Access and CHIP Reauthorization Act of 2015 Notice of Proposed Rulemaking, visit [The Federal Register](#) and follow the "Submit a comment" instructions.

The public can also submit comments in several other ways, including:
- By regular mail
- By express or overnight mail
- By hand or courier

Comments are due by **5:00 p.m. on Monday, June 27, 2016**
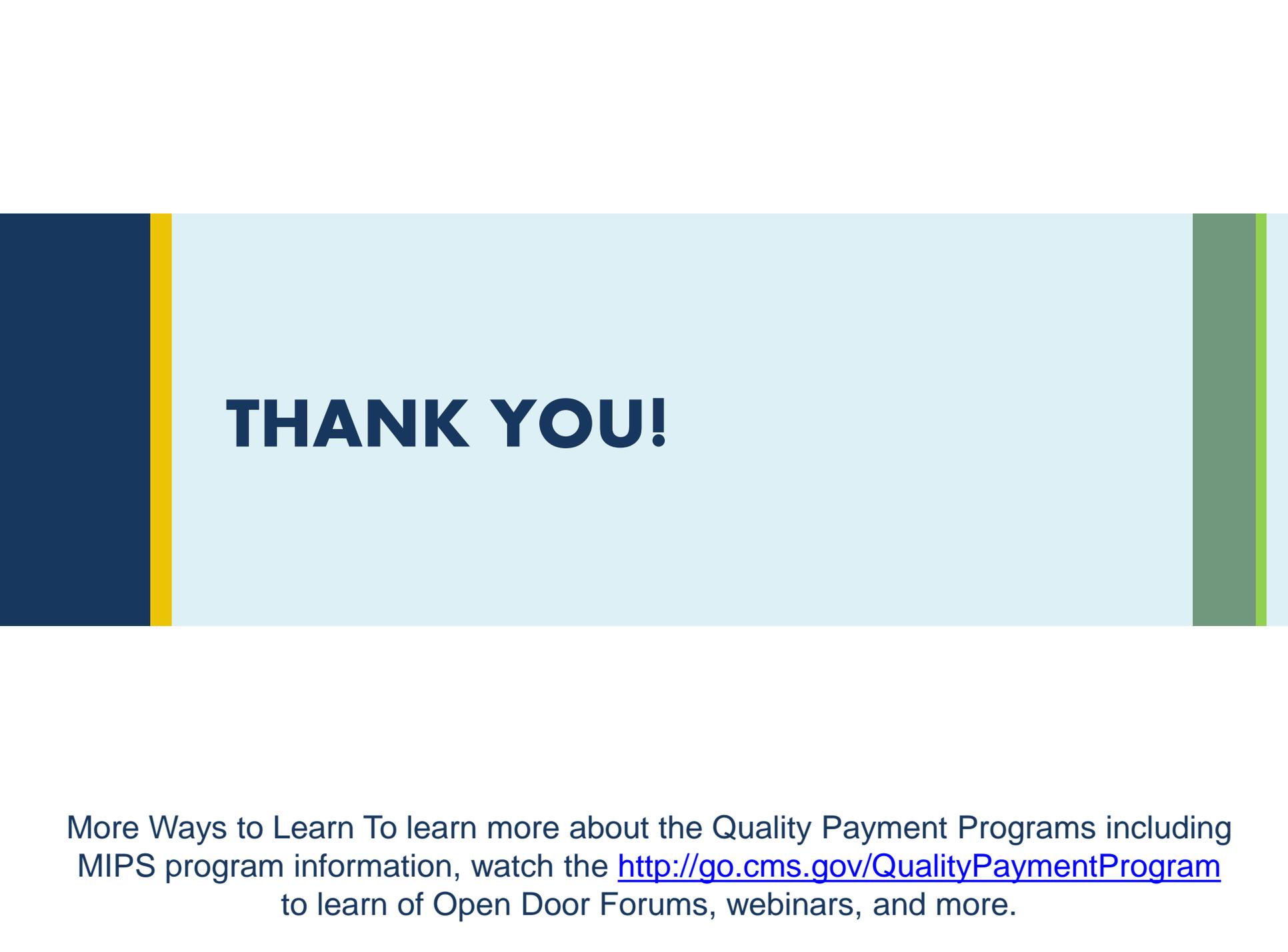
THANK YOU!

More Ways to Learn To learn more about the Quality Payment Programs including MIPS program information, watch the http://go.cms.gov/QualityPaymentProgram to learn of Open Door Forums, webinars, and more.

Hospital Inpatient Quality Reporting (IQR) Program Update

Artrina Sturges, EdD
Project Lead, IQR/Electronic Health Record (EHR) Alignment
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

June 23, 2016

QualityNet Secure Portal Update

- Receiving system functionality to accept Quality Reporting Data Architecture (QRDA) – I test files is **now available.**
- Submission of test files to the *QualityNet Secure Portal (QSP)* allows users to:
    - Test QRDA Category I file submissions and validate against 2016 CMS QRDA constraints
    - Validate file structure against the CMS receiving system
    - Identify errors, allowing for corrections prior to production data file submission

NOTES:
- ➢ Test file submissions **do not count** toward program requirements
- ➢ In December 2015, CMS hosted a webinar entitled *2016 CMS Implementation Guide Changes for Eligible Hospitals/Critical Access Hospitals*. The presentation provided an overview of the QRDA I standard updates and changes necessary for successful reporting in CY 2016. A recording of this webinar can be found at http://www.qualityreportingcenter.com/inpatient/ecqm-archived-events/.

Test QRDA – I Files: Preparation Checklist

CY 2016 Inpatient Quality Reporting (IQR) – Electronic Health Record (EHR) Alignment Preparation Checklist for eCQM Reporting – QRDA-I File Testing Instructions		
Due	**Task**	✓
NOW	☐ **Select** at least four eCQMs from the available <u>28 eCQMs List</u>.	☐
	☐ **Confirm** EHR System is certified to either 2014 or 2015 Office of the National Coordinator for Health Information Technology (ONC) Standards on the Certified Health IT Product List – <u>CHPL Website</u> and review which measures the system is certified to report.	
	☐ **Contact** the *QualityNet* <u>Help Desk</u> and obtain a *QualityNet Secure Portal* (QSP) account and the EHR Data Upload Role.	
	☐ **Confirm** QRDA -Category I files are constructed per the 2016 Centers for Medicare & Medicaid Services (CMS) Implementation Guide (IG) and 2016 CMS QRDA IG Appendix and Schematrons, and use the eCQM Specifications for Eligible Hospitals Update June 2015 on the <u>eCQM Library page</u>.	
	☐ **Download** the Pre-Submission Validation Application (PSVA) version 1.1.2 and the User Guide from the Secure File Transfer (SFT) of the <u>QSP</u> to validate the certified electronic health record technology (CEHRT)-generated QRDA – I files for test submission.	

Posted on QualityReportingCenter.com.

Pre-Submission Validation Application (PSVA) Tool

- Allows submitters to catch and correct QRDA formatting errors prior to data submission to CMS

- Is used voluntarily
  - CMS recommends vendors and facilities use the tool to test early and test often

- Is downloadable from the Secure File Transfer in the *QSP*
  - Install it on your system

NOTES:

➢ To submit files, you or your vendor will require a QSP User Account with an EHR Data Upload role

➢ For assistance with the PSVA tool, user accounts, or roles, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or 866.288.8912, 7 a.m.–7 p.m. Central Time, Monday through Friday

Archived and Upcoming Webinars

June 9 – *Preparation Checklist for CY 2016 eCQM Reporting*

July 25 – *Common Errors for QRDA-I Test Files: Session I*

Please visit the Quality Reporting Center website to obtain archived webinar materials, helpful tools, and information on upcoming presentations.

Resources

QualityNet Help Desk – PSVA and Data Upload Questions
- Qnetsupport@hcqis.org
- 1.866.288.8912, 7 a.m.–7 p.m. CT, Monday through Friday

eCQM General Program Questions – IQR Program
- https://cms-ip.custhelp.com
- 866.800.8765 or 844.472.4477, 7 a.m.–7 p.m. CT Monday through Friday (except holidays)

EHR (MU) Information Center – EHR Incentive Program Questions
- 888.734.6433, 7:30 a.m.– 6:30 p.m., CT Monday through Friday

The JIRA – ONC Project Tracking Website
- http://oncprojectracking.org Resource to submit questions and comments regarding:
  - Issues identified with eCQM logic
  - Clarification on specifications
  - The Combined QRDA IG for 2016
  - The EHR Incentive Program

Privacy & Security Update
Office of the Chief Privacy Officer
Office of the National Coordinator for Health IT, HHS

Electronic Exchange of PHI for Treatment and Health Care Operations

Peyton Isaac, BSN, JD
Senior Policy Analyst
Office of the Chief Privacy Officer (OCPO)
Office of the National Coordinator for Health Information Technology (ONC)

The Office of the National Coordinator for
Health Information Technology

What are Permitted Uses and Disclosures (PU&D)?

- Permitted Uses and Disclosures (PU&D) are situations in which a <u>covered entity</u> is permitted, but not required, to use and disclose PHI without first having to obtain a written authorization from the patient.

Basic Illustration of Permitted Uses
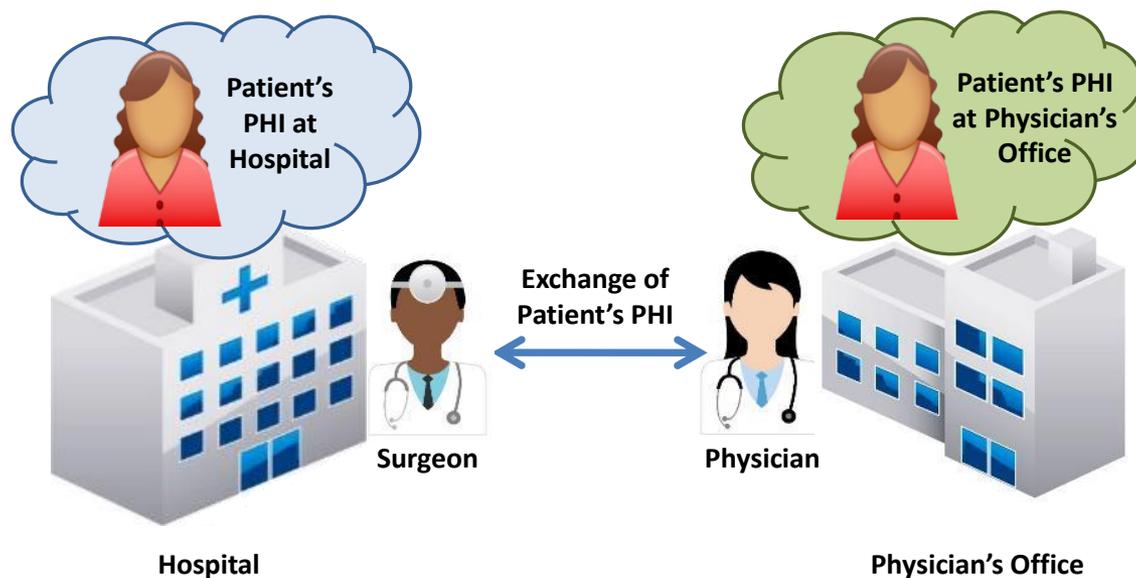
HIPAA Permitted Uses Drill Down

- FEAR: HIPAA makes it impossible to exchange health information electronically for patient care

- FACT: HIPAA permitted uses actually *allow* health information to be exchanged in a number of specific circumstances

  - » Providers can share PHI for **treatment**, broadly defined to include things like referrals, care management by someone hired by the provider, or transitions of care

  - » Providers and payers can share PHI for **operations** such as quality improvement, care coordination and other activities

  - » Under HIPAA, this type of sharing does not require a written patient authorization; however, other laws or organizational policies may impose such requirements

  - » Information can be shared electronically, supporting interoperability and making **information available to the right people at the right time for patient care**

- ONC & OCR released **fact sheets** and a series of **blog posts** with numerous examples of when electronic health information can be exchanged

The Office of the National Coordinator for
Health Information Technology

Permitted Uses Drill Down: Key Concepts for Exchange between Covered Entities

- "*May*" = discretion

  » Lawyers call it "permitted uses or disclosures"

  » Permitted is a key concept: it is the Covered Entity's choice

  » BAs can undertake the disclosure function on CEs behalf

    – E.g. HIEs

- Minimum necessary applies for exchange for health care operations

- What is permitted:

  » Access, use and disclosure for a covered entity's own treatment, payment or health care operations

  » Access and use by another CE, or disclosure to the other CE, for the recipient CE's treatment, payment or health care operations

- Who is liable when exchange occurs as permitted, and breach occurs under watch of recipient?

What Types of Activities are Considered Permitted Uses and Disclosure ?

- Conducting quality assessment and improvement activities

- Conducting case management and care coordination (including care planning)

- Conducting population-based activities relating to improving health or reducing health care cost

- Developing protocols

- Evaluating performance of health care providers and/or health plans

Hospital
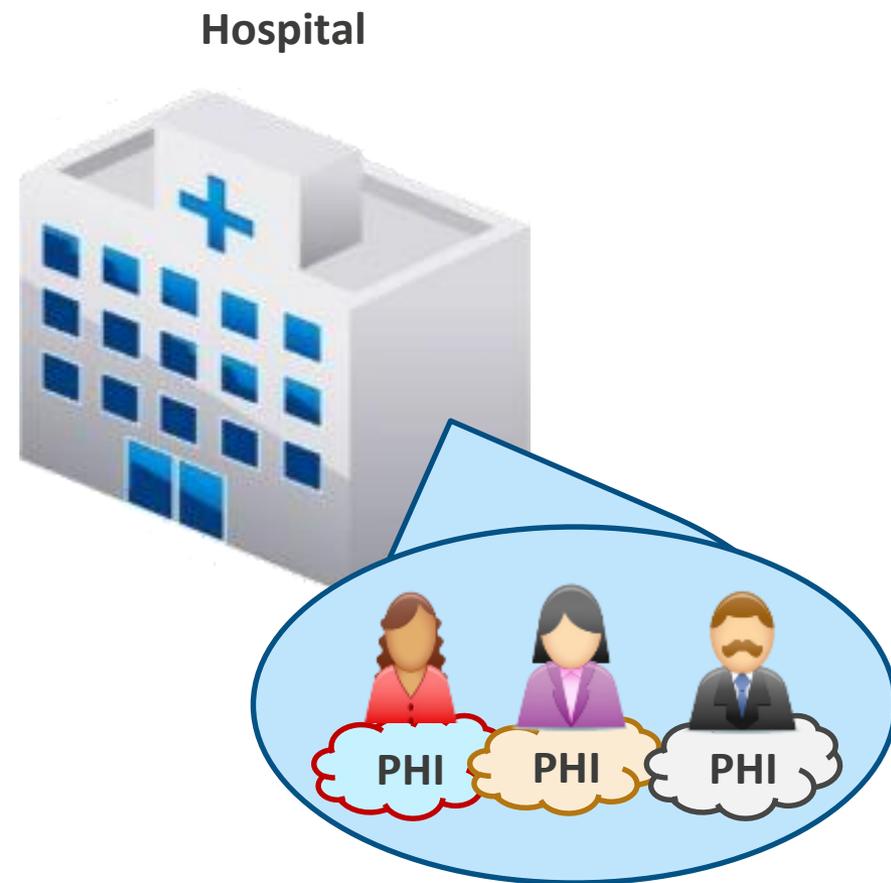
Interoperability Pledge

- **The Pledge:**

  » **Consumer Access:** To help consumers easily and securely access their electronic health information, direct it to any desired location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community.

  » **No Blocking/Transparency**: To help providers share individuals' health information for care with other providers and their patients whenever permitted by law, and not block electronic health information (defined as knowingly and unreasonably interfering with information sharing).

  » **Standards**: Implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information, and adopt best practices including those related to privacy and security.

The Office of the National Coordinator for
Health Information Technology

- OCPO launched a 4-part blog series entitled the "Real HIPAA Supports Interoperability" on February 4

    » Blog 1: The Real HIPAA Supports Interoperability

    » Blog 2: Background on HIPAA's PU&D

    » Blog 3: Examples of Care Coordination, Care Planning, Case Management

    » Blog 4: Examples of Quality Assurance and Population-Based Activities

- OCPO/OCR co-branded educational fact sheets that provide practical, plain language, examples with illustrations to supplement the blog series.
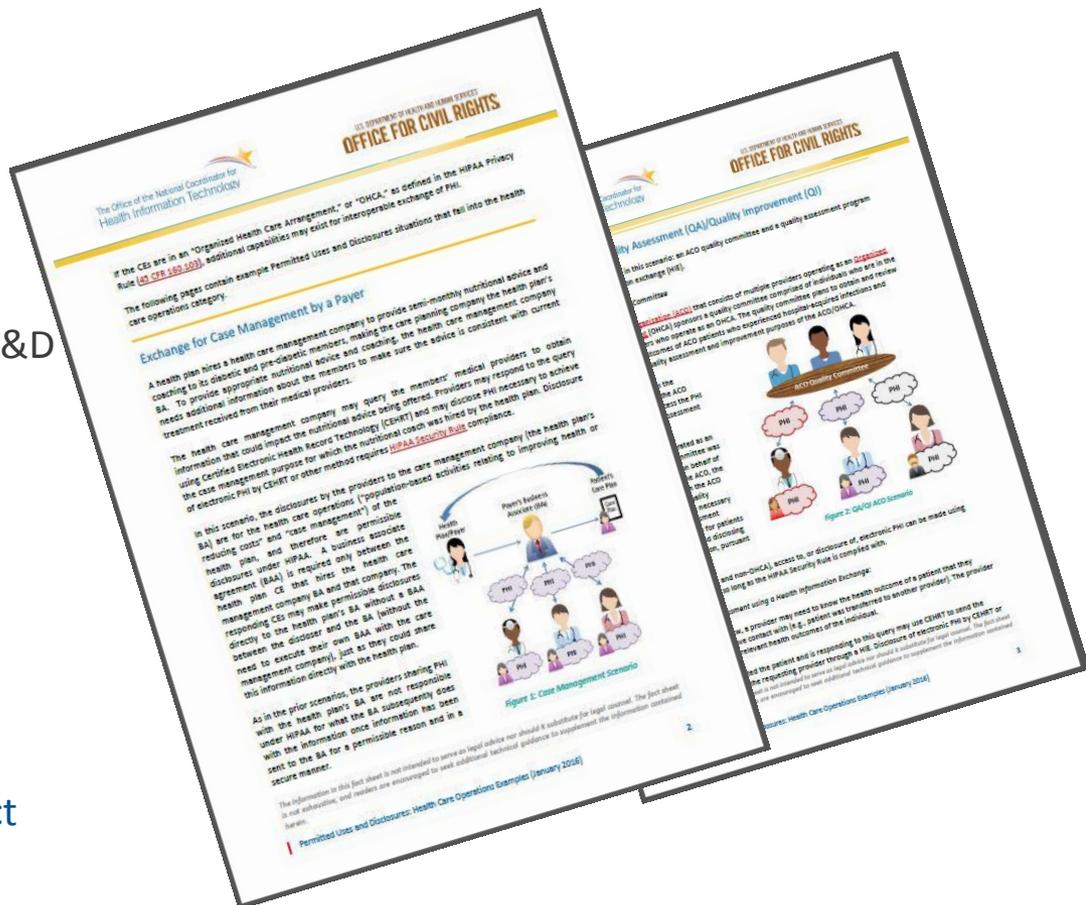
https://www.healthit.gov/newsroom/fact-sheets
Permitted Uses and Disclosures: Exchange for Health Care Operation [PDF - 1.3 MB] *
Permitted Uses and Disclosures: Exchange for Treatment [PDF - 1.1 MB] *

- https://www.healthit.gov/commitment

The Office of the National Coordinator for
Health Information Technology

Who's Made the Pledge

Health IT Developers

- Allscripts
- Aprima
- Athenahealth
- Cerner
- CPSI
- CureMD
- Epic
- GE Healthcare
- Greenway Health
- Intel
- McKesson
- MedHost
- Meditech
- NextGen
- Philips
- SureScripts
- Optum

Healthcare Systems

- Ascension Health
- Carolinas Healthcare
- Catholic Health Initiatives
- Community Health Systems
- Dignity Health
- Geisinger Health System
- Hospital Corporation of America (HCA)
- Intermountain Healthcare
- Johns Hopkins Medicine
- Kaiser Permanente
- Lifepoint Health
- Mountain States Health Alliance
- Partners Healthcare
- Tenet Healthcare
- Trinity Health
- University of Utah

Provider, Technology, and Consumer Organizations

- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- American Medical Group Association (AMGA)
- American Medical Informatics Association (AMIA)
- American Hospital Association (AHA)
- American Health Information Management Association (AHIMA)
- American Society of Clinical Oncology (ASCO)
- Center for Medical Interoperability
- College of Healthcare Informatics Management Executives (CHIME)
- Commonwell
- Health Information and Management Systems Society (HIMSS)
- Healthcare Leadership Council (HLC)
- National Partnership for Women and Families
- National Rural Health Association (NRHA)
- Premier healthcare alliance
- Sequoia Project

Future Topics

- July 18: Security Rule, Transmission and Liability.

- Questions?

www.healthit.gov

@ONC_HealthIT

HIPAA Access Guidance

Deven McGraw
Office for Civil Rights

General Right

- Individuals (or their personal representatives on their behalf) have the right to obtain access to, and/or a copy of, their protected health information in a designated record set maintained by or for a HIPAA covered entity
  - No later than within 30 days from when request was received, either by the CE or its BA
  - If unable to meet 30 days, CE may extend to 60 days
    - Must notify individual within initial 30 days
    - Only one extension per access request

Included in the "Designated Record Set"

- EHR and/or paper medical record

- Other medical, billing, payment, enrollment, claims records

- Clinical laboratory test reports

- X-rays, other images

- Wellness and disease management program information

- Clinical case notes

- Old/archived PHI

- PHI maintained by a business associate

Grounds for Denial of Access

- Unreviewable
  - Psychotherapy notes
  - Legal proceeding
  - Inmates (w/r/t copy)
  - DRS is part of research study still in progress, and individual agreed when consenting
  - Privacy Act protected records
  - Obtained under confidentiality

- Reviewable
  - Reasonably likely to endanger life or physical safety
  - Reasonably likely to cause substantial harm to a person referenced (not provider)
  - Access by personal representative reasonably likely to cause substantial harm

Providing Access

- Form and Format and Manner of Access - Provide in form and format requested if readily producible

  – Requests for paper copies

    - Provide paper copy

  – Requests for electronic copies

    - Provide electronic copy if readily producible

  – Manner requested

    - Convenient time and place

    - Mail

    - Email (encrypted or unencrypted)

Directing a copy to a third party

- When an individual or personal representative directs PHI to be sent to a third party
  - the same requirements (including fee limits, time limits, etc.) apply as for providing access directly to the individual or personal representative.
  - Requests must be in writing and clearly identify the recipient.

- When a third party requests PHI about an individual, permissible access fees depend on whether:
  - The third party is requesting on behalf of the individual, or
  - The third party is requesting on its own behalf (e.g., with an authorization).

- If the nature of the request is unclear, the CE may seek clarification from the individual.

Access and CEHRT

- Can use capabilities of CEHRT to help meet HIPAA obligations.

- If CE uses Certified EHR Technology, electronic PHI is readily producible in that format (if individual requests/agrees)

- For example, CEs can use VDT or API, or unsecure e-mail, mechanisms to fulfill access requests if individual requests or accepts the form/format/manner

- Individual always retains right to access PHI in a "designated record set" that is not available through CEHRT

- See chart in FAQs comparing HIPAA right to access and individual access opportunities under EHR Incentive Program

Unsecure transmission requested by individual

- We expect that CEs have capability to transmit PHI by e-mail, without unacceptable security risks to the CEs' systems

  – Limited exception may be where diagnostic image file sizes are too large to transmit via e-mail

- Thus, CE generally must agree to unsecure email transmission, but first must provide lite warning to individual of the risk that PHI could be read or accessed while in transit

- 2015 edition CEHRT capable of sending unencrypted e-mail directly

- CE cannot require that individual accept unsecure method of transmission

Unsecure transmission requested by individual

- CE is not responsible for:
  - disclosures during unsecure transmission to the individual, provided warning given and risks accepted
  - breach notification obligations
  - safeguarding information once delivered to the individual

- CE is responsible for:
  - reasonable safeguards (for example, addressing correctly)
  - <u>in all other contexts</u>, breach notification for unsecured transmissions, and may be liable for impermissible disclosures that occur in transit

Fees for copies

- Reasonable, cost-based
  - Labor for copying PHI
  - Supplies for creating copy
  - Postage, if mailed
  - Preparation of explanation or summary, if individual agrees

- Does not include*
  - Verification
  - Documentation
  - Search/retrieval
  - Maintaining systems
  - Recouping capital
  - Other costs
  * Even if authorized by state law

Calculating Costs for Access Fees

3 acceptable methods of calculating costs:

1.   Actual costs
     - <u>Actual</u> labor for copying (at reasonable rates, including only the time to create and send a copy in the form, format, and manner requested)
     - <u>Actual</u> postage
     - Supplies (paper, toner, CD, USB drive)

2.   Average costs
     - Cost schedule based on average labor costs for standard requests is okay
     - **<u>Per page fee acceptable only for paper records (copied or scanned)</u>**
     - Applicable supply and postage costs may be added to average labor costs

3.   Flat fee for electronic copies of electronic PHI only (up to $6.50).

Questions?

www.hhs.gov/hipaa

eCQI Resource Center
Thursday, June 23, 2016

Shanna Hartman and Edna Boone,

On behalf of CMS

Introduction

- eCQI - Electronic Clinical Quality Improvement

- eCQI Resource Center - One-stop shop for the most current resources to support electronic clinical quality improvement https://ecqi.healthit.gov

eCQI Resource Center Highlights

- eCQM Measures
- eCQM Tools and Key Resources
- eCQI Standards
- QDM
- Education
- Advanced Search

eCQI Resource Center Improvement

- Provide feedback at ecqi-resource-center@hhs.gov
- Submit key eCQI events for highlighting on the eCQI Resource Center
- Add a link to the eCQI Resource Center from your website
- Include a link to the eCQI Resource Center in your stakeholder communications

FOR MORE INFORMATION
ecqi-resource-center@hhs.gov

2016 Physician Quality Reporting System (PQRS) Electronic Reporting: Getting Started with Group Practice Reporting Option (GPRO)

EHR Vendor Workgroup
Sophia Autrey, CMS

June 23, 2016

PQRS is a provider-based program.

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Agenda

- PQRS Program Overview
- Getting Started with GPRO
- Electronic Reporting via EHR
- Resources & Where to Go for Help
- Questions & Answer Session

Acronyms

- CAHPS –Consumer Assessment of Healthcare Providers and Systems summary surveys
- CMS – Centers for Medicare & Medicaid Services
- CQMs – Clinical Quality Measures
- eCQMs – Electronic Clinical Quality Measures
- EP – Eligible Professional
- FFS – Fee-for-Service
- GPRO – Group Practice Reporting Option
- NPI – National Provider Identifier
- PQRS – Physician Quality Reporting System
- MPFS – Medicare Physician Fee Schedule
- TIN – Taxpayer Identification Number

2016 PQRS

PROGRAM OVERVIEW

What is PQRS?

- PQRS is a reporting program that promotes reporting of quality information by EPs

- Individual EPs and PQRS group practices that do not satisfactorily participate or satisfactorily report in PQRS will be subject to a payment adjustment

PQRS Program Year	PQRS Payment Adjustment Period	Negative Adjustment Rate
2013	2015	-1.5%*
2014	2016	-2.0%*
2015	2017	-2.0%*

*Applies to all of the EP's or group practice's Medicare Part B PFS covered professional services under MPFS during the payment adjustment period

How can EPs Participate in PQRS?

Individual EP

Analyzed by individual/rendering NPI and TIN combination

GPRO

Analyzed at the TIN level

See the [How to Get Started page](#) of the PQRS website for complete information on how to participate in PQRS.

Note: If reporting for PQRS through another CMS program, check the program's requirements for how to report quality data to avoid the PQRS negative payment adjustment.

High-Level PQRS Process

Step 1: Reporting and Participation
- Individual EP or PQRS group practice submits quality measures data

Step 2: Analysis
- CMS analyzes data for meeting reporting criteria

Step 3: Results and Feedback
- Access feedback reports on
  1) Success in reporting **OR**
  2) Subject to the PQRS negative payment adjustment

Step 4: Informal Review of Reporting Performance (Optional)
- Individual EP or PQRS group practices who feel the PQRS negative payment adjustment was assessed in error may request an informal review of their reporting performance

GETTING STARTED WITH GPRO

What is a Group Practice?

- Under 2016 PQRS, "group practice" is defined as a single TIN with 2 or more individual EPs (as identified by their individual NPI) who have reassigned their billing rights to the TIN
  - Group practices must register to participate in PQRS via GPRO to be analyzed at the group (TIN) level
  - Group practices that register to participate via GPRO are referred to as "PQRS group practices"

Why Participate via GPRO?

- Benefits of participating via GPRO
  - Billing and reporting staff may report one set of quality measures data on behalf of all EPs within a group practice, reducing the need to keep track of EPs' reporting efforts separately
  - EPs who have difficulty meeting the reporting requirements for individual EPs may benefit from group reporting

PQRS GPRO Criteria

A PQRS group practice must meet all of the following requirements in order to participate:

1.Group Size	2.Participation
3.Reporting Mechanism	4.Registration

PQRS GPRO Criteria:
1. GPRO Size Requirements

- The group practice will determine its size based on the number of EPs billing under the TIN at the time of GPRO registration.

- During GPRO registration, group size will be categorized as 2-24 EPs, 25-99 EPs, and 100 or more EPs.

- Reporting requirements and available reporting mechanisms may vary based on the group size.
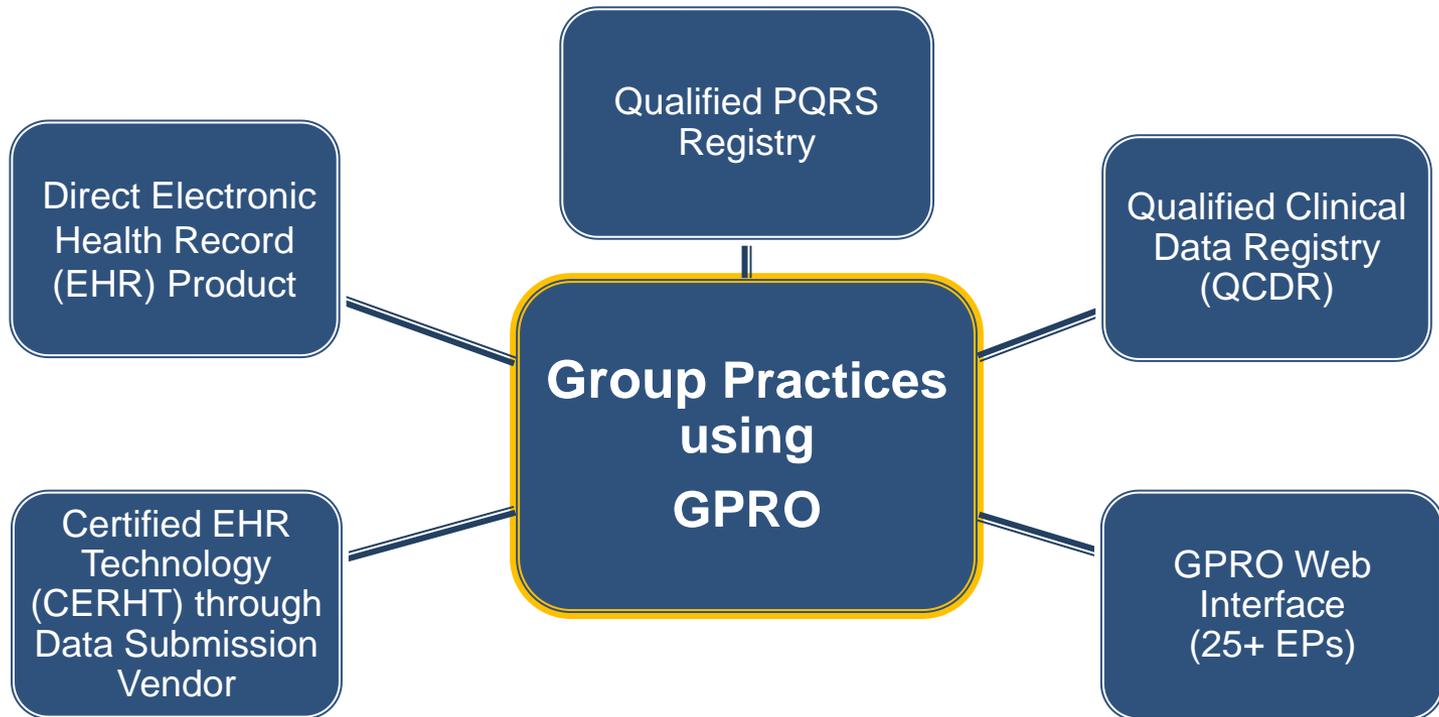
PQRS GPRO Criteria:
2. GPRO Participation Requirements

- Group practice must comply with all of the following requirements:
  - Have billed Part B MPFS on or after January 1, 2016 and prior to December 31, 2016
  - Agree to have the results of their performance on PQRS measures publicly posted on the [Physician Compare website](#)
  - Be able to comply with a secure mechanism for data submission

PQRS GPRO Criteria:
3. Select Reporting Mechanisms

Qualified PQRS Registry

Direct Electronic Health Record (EHR) Product

Qualified Clinical Data Registry (QCDR)

Group Practices using GPRO

Certified EHR Technology (CERHT) through Data Submission Vendor

GPRO Web Interface (25+ EPs)

*Note: Although required for PQRS group practices of 100 or more EPs, the CAHPS for PQRS survey is an extra and companion reporting mechanism for PQRS group practices with 2-99 EPs using an EHR, QCDR, or qualified registry, and for groups of 25-99 EPs reporting via GPRO Web Interface.

PQRS GPRO Criteria:
4. GPRO Registration

- Registration must be completed through the PV-PQRS Registration System via the [PQRS GPRO Registration webpage](#), between **April 1, 2016 - June 30, 2016**
  - Edits/cancellations are only allowed during the registration period
  - Group practices must indicate group size and select reporting mechanism during registration
- Group practices must have an approved EIDM account to register
  - At least one person from the group practice will need to obtain an EIDM account with a Security Official (SO) Role
  - Step-by-step instructions for setting up an EIDM account and assigning roles may be found in the "Obtain an EIDM Account to Access the Registration System" document on the PQRS GPRO Registration webpage

Registration Identification Number

- A Registration Identification Number is provided in the Confirmation Message that is emailed after a group practice completes GPRO registration
  - Vendors can work with their clients to confirm they received a Registration Identification Number
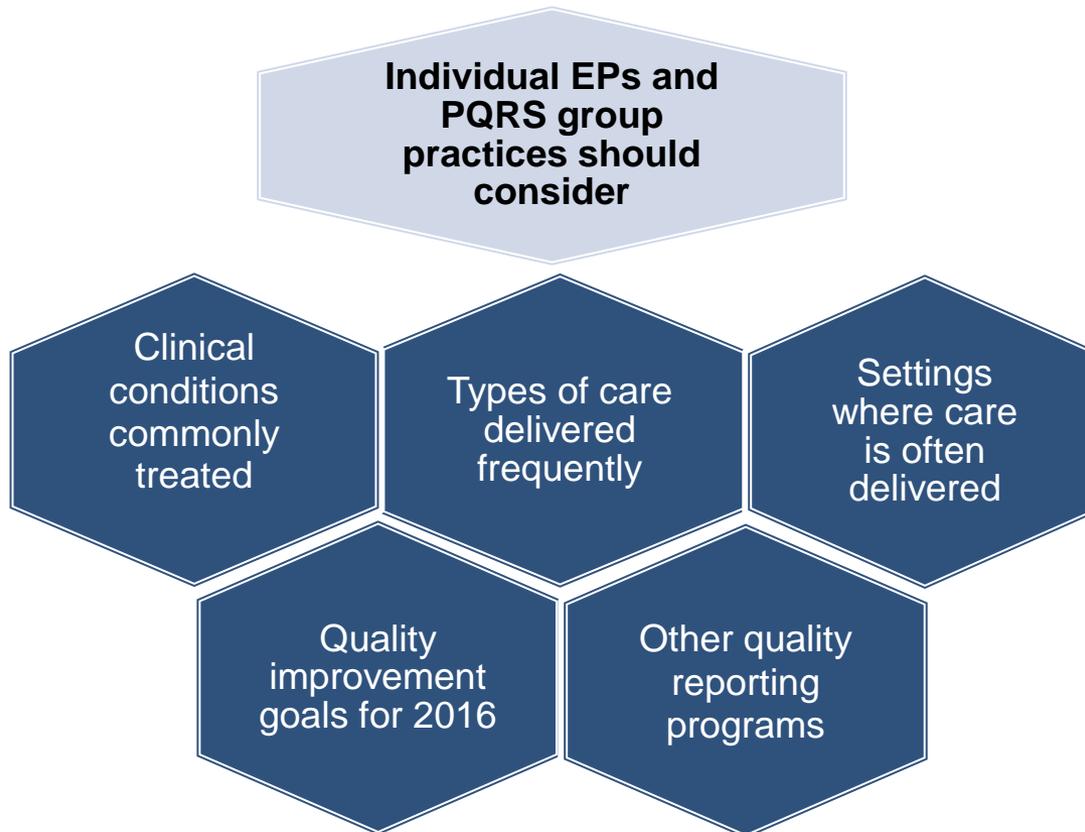
2016 PQRS

Electronic Reporting via EHR

Electronic Reporting Requirements

- Electronic reporters must:
  - Use EHR systems that are [certified EHR technology (CEHRT)](#)
  - Reference the "Medicare EHR Incentive Programs Clinical Quality Measures for Eligible Professionals" document posted on the [eCQM Library webpage](#) for reporting guidance
  - Use the July 2015 version of the eCQMs for 2016 reporting
  - Submit 12 months of data
  - Report on all payers

Selecting Measures

Individual EPs and PQRS group practices should consider

- Clinical conditions commonly treated
- Types of care delivered frequently
- Settings where care is often delivered
- Quality improvement goals for 2016
- Other quality reporting programs

- For a complete list of measures see the 2016 PQRS Measures List and the PQRS Web-Based Measure Search Tool is on the PQRS Measures Codes webpage

Note: The PQRS measure set and resulting specifications change from year to year

PQRS GPRO Electronic Reporting Requirements

SIZE	MEASURE TYPES	REPORTING MECHANISMS	SATISFACTORY REPORTING CRITERIA FOR PQRS GROUP PRACTICES
2-99 EPs	Individual Measures	Direct EHR Product **or** EHR Data Submission Vendor (DSV) Product	✓ Report 9 measures covering at least 3 NQS domains. ✓ If the group practice's direct EHR product or EHR DSV product does not contain patient data for at least 9 measures covering at least 3 National Quality Strategy (NSQ) domains, they must report all the measures where there is Medicare patient data. 　　✓ Report at least 1 measure for which there is Medicare patient data.

Note: PQRS group practices reporting electronically are required to use the July 2015 version of the *Electronic Clinical Quality Measures (eCQMs)* for 2016 reporting.

PQRS GPRO Electronic Reporting Requirements (cont.)

SIZE	MEASURE TYPES	REPORTING MECHANISMS	SATISFACTORY REPORTING CRITERIA FOR PQRS GROUP PRACTICES
2-99 EPs that elect to report CAHPS for PQRS 100+ EPs that must report CAHPS for PQRS	Individual Measures **and** CAHPS for PQRS	Direct EHR Product + CMS-Certified Survey Vendor **or** EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	✓ Must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. ✓ Report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR DSV product. Of the additional measures, report at least 1 measure for which there is Medicare patient data. ✓ If less than 6 measures apply, report all measures for which there is Medicare patient data.

Note: PQRS group practices reporting electronically are required to use the July 2015 version of the *Electronic Clinical Quality Measures (eCQMs)* for 2016 reporting.
Although required for PQRS group practices of 100 or more EPs, the CAHPS for PQRS survey is an extra and companion reporting mechanism for PQRS group practices with 2-99 EPs using an EHR, QCDR, or qualified registry, and for groups of 25-99 EPs reporting via GPRO Web Interface.

2016 Cross-Cutting Measures Requirement

- Cross-cutting measures are defined as measures that are broadly applicable
- Individual EPs and PQRS group practices are required to report one cross-cutting measure if they have at least one Medicare patient with a face-to-face encounter
  - The following resources can be found on the [PQRS Measures Codes webpage](#):
    - 2016 PQRS Measures List and 2016 Cross-Cutting Measures List - identify cross-cutting measures
    - 2016 PQRS List of Face-To-Face Encounter Codes - includes the billable codes that identify face-to-face encounters 2016

2016 PQRS

RESOURCES & WHERE TO CALL FOR HELP

Resources

- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

- **PFS Federal Regulation Notices**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

- **CMS Value-based Payment Modifier Website**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ PhysicianFeedback Program/ValueBasedPaymentModifier.html

- **Physician Compare**
  http://www.medicare.gov/physiciancompare/search.html

- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/

- **MLN Connects Provider eNews**
  http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

- **PQRS Listserv**
  https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

Where to Call for Help

- **QualityNet Help Desk:**

  866-288-8912 (TTY 877-715-6222) or qnetsupport@hcqis.org

  7:00 a.m.–7:00 p.m. CST Monday through Friday

  You will be asked to provide basic information such as name, practice, address, phone, and e-mail.

- **EHR Incentive Program Information Center:**

  888-734-6433 (TTY 888-734-6563)

- **Value Modifier Help Desk:**

  888-734-6433 Option 3 or pvhelpdesk@cms.hhs.gov

- **CPC Help Desk:**

  E-mail: cpcisupport@telligen.org

- **Physician Compare Help Desk:**

  E-mail: PhysicianCompare@Westat.com

Thank you!

The next vendor call will be held on **Thursday, July 21, 2016 from 12 – 1:30 p.m. ET**. CMS will share more information as it becomes available.