QUALITY PAYMENT PROGRAM — YEAR 2
PROPOSED RULE
Quality Component Reporting Requirements

Brief Synopsis: For the Quality Category, CMS is proposing continued reporting flexibility for eligible clinicians and groups for the 2018 performance year. Quality measure data submission requirements will not change and eligible clinicians will continue to earn partial credit for a measure if the measure reporting threshold of 50 percent is not met. New for the 2018 performance year, certain clinicians and groups can elect to have their quality score based on their hospital's value-based payment score. All current PQRS reporting mechanisms will remain available to eligible clinicians under MIPS.

CY2017 Final Rule	CY2018 Proposed Rule
Category Weighting • 60 percent for the 2019 adjustment year • 50 percent for 2020 • 30 percent for 2021 and beyond	Category Weighting CMS is proposing the Quality Component would contribute to the total score as follows: 60 percent for the 2020 adjustment year

Submission Criteria (claims, registry, EHR and QCDR) For a 12-month reporting period the MIPS eligible clinician or group would report at least 6 measures including at least 1 outcome measure. CMS did not finalize the requirement for a cross-cutting measure. If an applicable outcome measure is not available, the MIPS eligible clinician or group would be required to report one other high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures) in lieu of an outcome measure. If fewer than 6 measures apply to the individual MIPS eligible clinician or group, then the MIPS eligible clinician or group would be required to report on each measure is applicable. Alternatively, the MIPS eligible clinician or group will report one specialty-specific measure set, or the measure set defined at the subspecialty level, if applicable. If the measure set contains fewer than 6 measures, MIPS eligible clinicians will be required to report all available measures within the set. If the measure set contains 6 or more measures, MIPS eligible clinicians will be required to report at least six measures within the set. Regardless of the number of measures that are contained in the measure set, MIPS eligible clinicians reporting on a measure set will be required to report at least one outcome measure or, if no outcome measures are available in the measure set, report another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care within the measure set in lieu of an outcome measure. MIPS eligible clinicians may choose to report measures in addition to those contained in the specialty-specific measure set will not be penalized for doing so, provided such MIPS eligible clinicians follow all other requirements.	Submission Criteria (claims, registry, EHR and QCDR) CMS is not proposing any changes to the submission criteria or definitions established for measures. (pg. 105) NEW For the 2018 performance period and beyond, CMS is proposing to allow individual MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories (pg. 116).

Data Validation CMS finalized a data validation process, which will apply for claims and registry submissions to validate whether MIPS eligible clinicians have submitted all applicable measures when MIPS eligible clinicians submit fewer than six measures or do not submit the required outcome measure or other high priority measure if an outcome measure is not available, or submit less than the full set of measures in the MIPS eligible clinicians' applicable specialty set.	Data Validation CMS is not proposing changes to its data validation (Eligible Measure Applicability) process.

Submission Criteria (web interface) For groups of 25 or more MIPS eligible clinicians who want to report via the CMS Web Interface, the following requirements must be met: —Report on all measures included in the CMS Web Interface completely, accurately, and timely by populating data fields for the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the group's sample for each module/measure. If the pool of eligible assigned beneficiaries is less than 248, then the group would report on 100 percent of assigned beneficiaries. —A group would be required to report on at least one measure for which there is Medicare patient data. —Groups reporting via the CMS Web Interface are required to report on all of the measures in the set. Any measures not reported would be considered zero performance for that measure in our scoring algorithm. —Groups may register for this mechanism and have zero Medicare patients assigned and sampled to them. If a group has no assigned patients, then the group, or individual MIPS eligible clinicians within the group, would need to select another mechanism to submit data to MIPS.	Submission Criteria (web interface) CMS is not proposing any changes to the submission criteria for quality measures for groups reporting via the CMS Web Interface.

Submission Criteria (Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey) Registered groups of two or more MIPS eligible clinicians may voluntarily elect to participate in the CAHPS for MIPS survey. Those choosing to participate in the CAHPS survey earn bonus points under the Quality performance category. Groups electing to report the CAHPS for MIPS survey are required to register for the reporting of data. Currently, the CAHPS for PQRS beneficiary sample is based on Medicare claims data. Therefore, only Medicare beneficiaries can be selected to participate in the CAHPS survey.	Submission Criteria (Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey) CMS is not proposing any changes to the performance criteria for quality measures for groups electing to report the CAHPS for MIPS survey. NEW CMS is proposing for the Quality Payment Program Year 2 and future years that the survey administration period would, at a minimum, span over 8 weeks and would end no later than February 28th following the applicable performance period. In addition, CMS proposes to further specify the start and end timeframes of the survey administration period through our normal communication channels. NEW CMS is proposing for the Quality Payment Program Year 2 and future years to remove two SSMs, specifically, “Helping You to Take Medication as Directed” and “Between Visit Communication” from the CAHPS for MIPS survey.

Data Completeness Criteria For the transition year of MIPS, CMS finalized a 50 percent data completeness threshold for claims, registry, QCDR, and EHR submission mechanisms. The 50 percent threshold is consistent with the current PQRS program. Individual MIPS eligible clinicians or groups, if reporting using a registry, QCDR or EHR, will need to report on at least 50 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for the performance period. Individual MIPS eligible clinicians submitting data on quality measures data using Medicare Part B claims, would report on at least 50 percent of the Medicare Part B patients seen during the performance period to which the measure applies. Groups submitting quality measures data using the CMS Web Interface or a CMS-approved survey vendor to report the CAHPS for MIPS survey must meet the data submission requirements on the sample of the Medicare Part B patients CMS provides.	Data Completeness Criteria CMS is proposing to maintain a 50 percent data completeness threshold for claims, registry, QCDR and EHR submission mechanisms for the 2018 performance year and to increase the threshold to 60 percent for the 2019 performance period (pg. 113). Consistent with the current performance period, those clinicians who utilize a QCDR, qualified registry, or EHR submission must contain a minimum of one quality measure for at least one Medicare patient. NEW CMS is proposing that MIPS eligible clinicians would receive 1 point for measures that fall below the data completeness threshold, with an exception for small practices of 15 or fewer who would still receive 3 points for measures that fail data completeness (pg. 116).

Those clinicians who utilize a QCDR, qualified registry, or EHR submission must contain a minimum of one quality measure for at least one Medicare patient. For the transition year, MIPS eligible clinicians whose measures fall below the data completeness threshold of 50 percent would receive 3 points for submitting the measure. 3 points allows an eligible clinician to avoid a negative adjustment in 2019.	

Global and Population-Based Measures CMS finalized the all-cause hospital readmissions (ACR) measure from the physician value modifier program as part of the quality measure domain for the MIPS total performance score. The measure will not be applied to solo practices or small groups of 15 or less. CMS will apply the ACR measure to groups of 16 or more who meet the case volume of 200 cases.	Global and Population-Based Measures CMS is not proposing any changes for the global and population-based measures.

Putting the Pieces Together
Practical Solutions for the GI Practice

MIPS Measures CMS finalized the following GI measures for inclusion in MIPS for the 2017 Performance Period: #185 – Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use #320 – Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients #439 – Age Appropriate Screening Colonoscopy #425 – Photodocumentation of Cecal Intubation CMS finalized the Gastroenterology Measure Set, which includes 17 measures. CMS revised the measure set from the proposed set with the following changes: 1) addition of previously identified cross-cutting measures that are relevant for the specialty set (#047, #128, #130, #226, #317, #374, #402, #431), 2) removal of #113 per a commenter's recommendation as CMS agrees with their assessment, and 3) addition of IBD measures as they are applicable to the gastroenterology specialty (#271, #275).	MIPS Measures None of the endoscopy measures have been proposed for removal The new MIPS quality measures proposed for inclusion in MIPS for the 2018 performance period and future years are found in Table A (pg. 819). The proposed new and modified MIPS specialty sets for the 2018 performance period and future years are listed in Table B, and include existing measures that are proposed with modifications, new measures, and measures finalized in the CY 2017 Quality Payment Program final rule (Gastroenterology pg. 848-852). MIPS quality measures to be removed only from specialty sets (Table C.1) (pg. 1017). Note: CMS has removed cross-cutting measures from most specialty sets, but chose to retain the cross-cutting measures in Family Practice, Internal Medicine and Pediatrics specialty sets because they are frequently used in these practices MIPS quality measures to be removed from the MIPS program for the 2018 performance period (Table C.2) (pg. 1020). Cross Cutting Measures (Table D) (pg. 1024). Measures with Substantive Changes (Table E) (pg. 1026). • CAHPS for MIPS (#321) • Tobacco Use: Screening and Cessation Intervention (#226) • BMI Screening and Follow-Up Plan (#128) • Influenza Immunization (#110)

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Topped Out Measures	Topped Out Measures NEW CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th year. In the 4th year, if finalized through rulemaking, the measure would be removed and no longer be available for reporting during the performance period. This proposal provides a path toward removing topped out measures over time and applies to the MIPS quality measures (pg. 129). (Timeline example, pg. 130). QCDR measures that consistently are identified as topped out according to the same timeline as proposed below, would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the comment and rulemaking process. CMS proposes to phase in special scoring for measures identified as topped out in the published benchmarks for two consecutive performance periods, starting with the select set of highly topped out measures for the 2018 MIPS performance period. pg. 130 For all other measures, the timeline would apply starting with the benchmarks for the 2018 MIPS performance period. Thus, the first year any other topped out measure could be proposed for removal would be in rulemaking for the 2021 MIPS performance period, based on the benchmarks being topped out in the 2018, 2019, and 2020 MIPS performance periods. If the measure benchmark is not topped out during one of the three MIPS performance periods, then the lifecycle would stop and start again at year 1 the next time the measure benchmark is topped out.

	CMS proposes to phase in this policy starting with a select set of six highly topped out measures. • Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin • Melanoma: Overutilization of Imaging Studies in Melanoma • Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) • Image Confirmation of Successful Excision of Image-Localized Breast Lesion • Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description • Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy

Non-Outcome Measure	Non-Outcome Measure CMS is not proposing to remove non-outcome measures in this proposed rule. However, CMS seeks comment on what the best timeline for removing both non-outcome and outcome measures that cannot be reliably scored against a benchmark for 3 years. CMS intends to revisit this issue and make proposals in future rulemaking (pg. 133).

Quality Measures Determined to be Outcome Measures	Quality Measures Determined to be Outcome Measures No new proposals. CMS utilizes the following as a basis to determine if a measure is considered an outcome measure: • Measure Steward and National Quality Forum (NQF) designation – For most measures, CMS will utilize the designation as determined by the measure steward and the measure's NQF designation to determine if it is an outcome measure or not. If this is not clear, CMS will consider the following step. • Utilization of the CMS Blueprint definitions for outcome measures: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf • An outcome of care is a health state of a patient resulting from health care. Outcome measures are supported by evidence that the measure has been used to detect the impact of one or more clinical interventions. Clinical analysts are utilized to evaluate the measure.

Facility-Based Clinicians and Groups	Facility-Based Clinicians and Groups NEW Clinicians and groups electing facility-based measurement will receive a quality score based on their facility's Hospital VBP. CMS proposes to limit the facility-based opportunity to clinicians who practice primarily in the hospital (pg. 27). A MIPS eligible clinician is eligible for facility-based measurement under MIPS if he/she furnishes 75 percent or more of their covered professional services in sites of service identified by the place of service codes (POS) as an inpatient hospital (POS 21) or emergency department (POS 23) based on claims for a period prior to the performance period as specified by CMS (pg. 662). A facility-based group is a group in which 75 percent or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals (pg. 380).