

Putting the Pieces Together

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MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) QUALITY CATEGORY

QUALITY PAYMENT PROGRAM FINAL RULE SUMMARY

Synopsis —

For the Quality performance category, CMS finalized the proposal for greater reporting flexibility for eligible clinicians and groups by reducing the number of quality measures from nine (as required under the current Physician Quality Reporting System (PQRS)) to six, and eliminating the requirement to fulfill specific measure Clinical Quality Domains. CMS also steps away from the current PQRS “all or nothing” participation approach and instead proposes to give eligible clinicians and groups credit for the performance of any measures reported. In the initial year of MIPS, eligible clinicians will earn partial credit for a measure if the measure reporting threshold (50 percent) is not met. All current PQRS reporting mechanisms will remain available to eligible clinicians under MIPS.

MIPS eligible clinicians can use CMS' [interactive tool](#) to review available quality measures for reporting. Additionally, visit www.giquic.org to learn how the GIQuIC registry can help you meet the Quality Category requirements. Provisions for the Quality category start on page 323 of the [final rule](#).

In Brief: What Do You Need to Do?

- 1. All participants:** Report at least 6 quality measures, or a specialty measure set, including an outcome measure, for a minimum of 90 days.
- 2. Groups using the web interface:** Report 15 quality measures for a full year.
- 3. Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.

Putting the Pieces Together

Practical Solutions for the GI Practice



PROPOSED RULE	FINAL RULE
CONTRIBUTION TO COMPOSITE PERFORMANCE SCORE (CPS)	
<p>The Quality performance category will contribute the following to the CPS:</p> <ul style="list-style-type: none"> •50 percent for the 2019 adjustment year •45 percent for 2020 •30 percent for 2021 and beyond 	<p>CMS is finalizing the following modifications:</p> <ul style="list-style-type: none"> • 60 percent for the 2019 adjustment year • 50 percent for 2020 • 30 percent for 2021 and beyond
DATA SUBMISSION CRITERIA INDIVIDUAL ELIGIBLE CLINICIANS AND GROUPS	
<p>CMS proposed that individual MIPS eligible clinicians and groups submitting data via claims, electronic health record (EHR), registries, and Qualified Clinical Data Registries (QCDRs) would be required to meet the following submission criteria during the 12-month reporting period:</p> <p>—At least six measures including one cross-cutting measure (if patient-facing) and including at least one outcome 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 six measures apply to the individual MIPS eligible clinician or group, then CMS proposed the MIPS eligible clinician or group would be required to report on each measure that is applicable.</p> <p>—MIPS eligible clinicians and groups will have to select their measures from either the list of all MIPS measures or a set of specialty-specific measure set.</p> <p>CMS intends to develop a validation process (likely similar to the measure applicability validation — MAV — process) to review and validate a MIPS eligible clinician’s or group’s ability to report on at least six quality measures, or a specialty-specific measure set, with a sufficient sample size, including at least one cross-cutting measure (if the MIPS eligible clinician is patient-facing) and either an outcome measure if one is available or another high priority measure.</p>	<p>CMS is modifying the proposal for the transition year of MIPS and finalizing that for the applicable performance 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 as applicable.</p> <p>MIPS eligible clinicians and groups will have to select measures from the list of all MIPS measures or a set of specialty-specific measures.</p> <p>Alternatively, for the 2017 performance period, 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,</p>

Putting the Pieces Together

Practical Solutions for the GI Practice



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.

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.

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.

CMS is finalizing its proposal for reporting quality measures via the CMS Web Interface without modification.

CONSUMER ASSESSMENT OF HEALTH CARE PROVIDER AND SYSTEMS (CAHPS) PERFORMANCE CRITERIA

CMS proposed to allow registered groups of two or more MIPS eligible clinicians to voluntarily elect to participate in the CAHPS for MIPS survey. Those choosing to participate in the CAHPS survey would earn bonus points under the Quality performance category.

Groups electing to report the CAHPS for MIPS survey would be 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.

CMS finalized the requirements for reporting the CAHPS for MIPS Survey as proposed.

Putting the Pieces Together

Practical Solutions for the GI Practice



DATA COMPLETENESS CRITERIA

MIPS eligible clinicians and groups who do not meet the following proposed reporting criteria would fail the quality component of MIPS:

—Individual MIPS eligible clinicians or groups submitting data on quality measures using QCDRs, qualified registries, or via EHR need to report on at least 90 percent of the MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer (both Medicare and non-Medicare) for the performance period.

—Individual MIPS eligible clinicians submitting data on quality measures data using Medicare Part B claims, would report on at least 80 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 would need to meet the data submission requirements on the sample of the Medicare Part B patients CMS provides.

CMS proposed that measures that fell below the data completeness threshold would be assessed a zero.

The following modifications were made to the data completeness criteria:

—For the transition year of MIPS, CMS will finalize 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.

— For the 2018 performance period, CMS is finalizing a 60 percent data completeness threshold for claims, registry, QCDR, and EHR submission mechanisms. CMS anticipates that in the 2021 MIPS payment year and beyond, for performance periods occurring in 2019 forward, as MIPS eligible clinicians gain experience with the MIPS it will further increase these thresholds over time.

— 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.

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.

Putting the Pieces Together

Practical Solutions for the GI Practice



QUALITY MEASURES FOR NON-PATIENT FACING CLINICIANS

CMS proposed that non-patient-facing MIPS eligible clinicians would be required to meet the otherwise applicable submission criteria, but would not be required to report a cross-cutting measure.

CMS finalized the proposal and removed the exception regarding the cross-cutting measure, as the cross-cutting requirement was not finalized.

GLOBAL AND POPULATION-BASED MEASURES

CMS proposed to use the acute and chronic composite measures of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) that meet a minimum sample size in the calculation of the quality performance score. Eligible clinicians will be evaluated on their performance on these measures in addition to the six required quality measures. The proposed minimum case number requirement for these measures is 20. CMS also proposes to include the all-cause hospital readmissions measure from the current physician value modifier for calculating the quality performance score.

CMS proposes to limit this measure to groups with 10 or more clinicians and to maintain the current value modifier requirement of 200 cases. The proposed claims-based population measures would rely on the same two-step attribution methodology that is currently used in the value modifier.

CMS did not finalize the proposal to use the acute and chronic composite measures of AHRQ Prevention Quality Indicators (PQIs) in the quality score. However, CMS will calculate these measures for all MIPS eligible clinicians and provide feedback for informational purposes as part of the MIPS feedback.

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. However, 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.

Putting the Pieces Together

Practical Solutions for the GI Practice



QUALITY MEASURE SELECTION

In the first year of MIPS, CMS proposed to maintain a majority of previously implemented measures in PQRS, as well as new measures.

For purposes of assessing performance of MIPS eligible clinicians on the quality performance category, CMS will use quality measures included in the MIPS final list of quality measures. Specifically, CMS is finalizing:

- Table A: Individual Quality Measures Available for MIPS Reporting in 2017
- Table B: List of quality measures that do not require data submission
- Table D: Newly proposed measures
- Table E: Specialty-specific measure sets
- Table F: Measures for removal
- Table G: Measures that will have substantive changes for the 2017 performance period

Quality measures will be selected annually through a call for quality measures process, and a final list of quality measures will be published in the *Federal Register* by November 1 of each year.

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

CMS did not finalize its proposal to remove the following measure. Rather, CMS will maintain the following measure for the 2017 Performance Period:

- #425 – Photodocumentation of Cecal Intubation

CMS finalized the **Gastroenterology Measure Set**, which includes 16 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

Putting the Pieces Together

Practical Solutions for the GI Practice



assessment, and 3) addition of IBD measures as they are applicable to the gastroenterology specialty (#271, #275).

MIPS Quality Category Gastroenterology Measure Set

- Age Appropriate Screening Colonoscopy (#439)
- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (#320)
- Care Plan (#47)
- Closing the Referral Loop: Receipt of Specialist Report (#374)
- Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use (#185)
- Documentation of Current Medications in the Medical Record (#130)
- Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis (#401)
- Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options (#390)
- Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy (#275)
- Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury - Bone Loss Assessment (#271)
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (#128)
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (#317)
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (#431)

Putting the Pieces Together

Practical Solutions for the GI Practice



	<ul style="list-style-type: none"> • Screening Colonoscopy Adenoma Detection Rate (#343) • Tobacco Use and Help with Quitting among Adolescents (#402)
QCDR MEASURES	
<p>CMS must publish on its website the list of quality measures used by QCDRs on the CMS website and proposes to post quality measures for use by QCDRs in the spring of 2017 for the initial performance period and no later than January 1 for future performance periods. Quality measures that are owned or developed by the QCDR entity and proposed by the QCDR for inclusion in MIPS but are not a part of the MIPS quality measure set are considered non MIPS measures.</p>	<p>CMS is finalizing the proposal that for purposes of assessing performance of MIPS eligible clinicians on the quality performance category, CMS will use quality measures used by QCDRs. In the circumstances where a QCDR wants to use a non-MIPS measure for inclusion in the MIPS program for reporting, those measures will go through a CMS approval process during the QCDR self-nomination period. CMS is also finalizing the proposal to post the quality measures for use by qualified clinical data registries in the spring of 2017 for the initial performance period and no later than January 1 for future performance periods.</p>
ADDITIONAL SYSTEM MEASURES	
	<p>CMS will consider an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the MIPS eligible clinician's quality score. CMS is not proposing an option for the transition year of MIPS because there are several operational considerations that must be addressed before this option can be implemented.</p>