Department of Health and Human Services
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FOLLOWUP REVIEW: CMS'S MANAGEMENT OF THE QUALITY PAYMENT PROGRAM

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Why OIG Did This Review

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) enacted clinician payment reforms designed to promote quality and value of care. These reforms, known as the Quality Payment Program (QPP), are a significant shift in how Medicare calculates compensation for clinicians and require the Centers for Medicare & Medicaid Services (CMS) to develop a complex system for measuring, reporting, and scoring the value and quality of care. The first performance year began on January 1, 2017.

In 2016, OIG conducted an early implementation review of CMS's management of the QPP. While we found that CMS had made significant progress in developing the QPP, we identified two vulnerabilities that were critical for CMS to address in 2017: (1) providing sufficient guidance and technical assistance to ensure that clinicians were ready to participate in the QPP, and (2) developing information technology (IT) systems to support data reporting, scoring, and payment adjustment. OIG conducted this followup review to assess CMS's progress in mitigating these potential vulnerabilities and to identify emerging risks.

How OIG Did This Review

We interviewed CMS staff and reviewed internal CMS documents as well as publicly available information. We conducted qualitative analysis to identify key milestones (both those achieved and those yet to come), priorities, and challenges related to QPP implementation.

What OIG Found

During 2017, CMS made significant efforts to address the two vulnerabilities that OIG identified in its 2016 management review—developing IT systems and preparing clinicians to participate in the QPP.

With regard to IT, CMS appears on track to deploy the systems needed for data submission by January 1, 2018. It has added new content and functionality to the public website; deployed an IT product to make eligibility determinations; and tested, but not yet fully deployed, applications to support data submission and real-time scoring.

With regard to clinician readiness, CMS has conducted outreach, communicated eligibility information, issued subregulatory guidance, and established a Service Center to respond to questions. CMS also awarded a variety of technical assistance contracts; however, contractors' efforts to date have focused primarily on general education for a broad audience rather than specialized technical assistance to address practice-specific needs. Clinician feedback collected by CMS demonstrates widespread awareness of the QPP, but also uncertainty about eligibility, data submission, and other key elements of the program.

With regard to emerging challenges, we found that CMS has not yet developed a comprehensive program integrity plan for the QPP. Appropriate oversight—particularly to ensure the accuracy of clinician-submitted data—is critical to prevent improper QPP payment adjustments. Although CMS included oversight provisions in the QPP final rule for 2017 and has initiated oversight planning, it still needs to clearly designate leadership responsibility for QPP program integrity and develop a plan to prevent and address fraud and improper payments.

Key Takeaway

CMS has made progress towards implementing the QPP, but challenges remain. CMS appears on track to deploy the IT systems needed for data submission by January 1, 2018. OIG has identified two vulnerabilities that are critical for CMS to address in 2018 because of their potential impact on the program's success:

(1) If clinicians do not receive sufficient technical assistance, they may struggle to succeed under the QPP or choose not to participate.

(2) If CMS does not develop and implement a comprehensive program integrity plan for the QPP, the program will be at greater risk of fraud and improper payments.

Background

The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA) was enacted in April 2015 with bipartisan support.[1] The Centers for Medicare & Medicaid Services (CMS) is implementing core provisions of MACRA as the Quality Payment Program (QPP), a set of clinician payment reforms designed to put increased focus on the quality and value of care.[2, 3] The QPP is a significant shift in how Medicare calculates payment for clinicians and requires CMS to develop a complex system for measuring, reporting, and scoring the value and quality of care.

In 2016, OIG conducted an early implementation review of CMS's management of the QPP.[4] We found that CMS had made significant progress towards implementing the QPP, including fostering clinician acceptance, adopting integrated business practices, building IT systems, and developing key program policies. However, our review also identified two potential vulnerabilities that were critical for CMS to address in 2017 because of their potential impact on the program's success:

(1) *Completing information technology systems to support critical QPP functions*. In the past, CMS has experienced delays and complications related to major information technology (IT) initiatives. If CMS does not complete the complex IT systems underlying the QPP on schedule, implementation of quality-based payment adjustments may be delayed.

(2) *Ensuring clinician readiness to participate in the QPP*. If clinicians lack sufficient information and assistance, they may struggle to meet QPP reporting requirements or choose not to participate at all.

The objectives of this followup review were to assess CMS's progress in mitigating these potential vulnerabilities and to identify emerging challenges. If CMS fails to sufficiently address these issues, the QPP may be unable to achieve its goal of promoting high-value care and patient outcomes while minimizing burden on clinicians.

Clinician Payment Under Medicare Part B

Medicare pays clinicians (such as physicians and nurse practitioners) for their services through the Part B benefit. Clinician services include office visits and surgical, diagnostic, and therapeutic procedures. CMS bases its payment rates for over 7,000 clinician services on the Medicare Physician Fee Schedule.[5, 6] Prior to the passage of MACRA, these payment rates were intended to be updated annually using the sustainable growth rate (SGR) formula.[7] The SGR was designed by Congress to control Medicare spending by either reducing or increasing Part B payment rates when spending fell above or below a set target.[8, 9] However, in practice, the SGR led to projected reductions in annual payment rates that many stakeholders criticized as being too severe. As a result, Congress overrode the SGR payment-rate reduction each year from 2003 to 2015 and opted to either maintain or increase payment rates, an annual process that came to be known as the "doc fix."[10]

Overview of the Quality Payment Program

MACRA requires that on January 1, 2019, CMS must begin making Medicare Part B payment adjustments to clinicians based on the quality and value of care they provide rather than based on the volume of services provided. These adjustments are determined by clinicians' performance as assessed through one of two tracks: the Merit-Based Incentive Payment System (MIPS) or Advanced Alternative

Payment Models (Advanced APMs). CMS refers to these two tracks together as the QPP. (See Exhibit 1 for a summary of the QPP program tracks.)

Exhibit 1. Overview of Tracks for the Quality Payment Program

Merit-Based Incentive Payment System (MIPS) Track		Advanced Alternative Payment Models (Advanced APMs) Track

• Components of MIPS final score:
  ○ Quality
  ○ Advancing Care Information
  ○ Improvement Activities
  ○ Cost (not included in 2017 MIPS score)
• Payment adjustment: MIPS must be budget neutral, so CMS may scale positive payment adjustments as needed to achieve neutrality. High performers will be eligible for additional payments for exceptional performance.
	OR	• CMS determines which models meet criteria for Advanced APMs.
		• Qualifying APM Participants have a certain proportion of their Medicare payments or patients through the Advanced APM.
		• Payment adjustment: Qualifying APM Participants will receive an annual 5% lump-sum bonus from 2019 through 2024. Beginning in 2026, they will receive higher physician fee-schedule updates, compounded annually.

Source: OIG analysis of CMS's implementation of QPP, 2017.

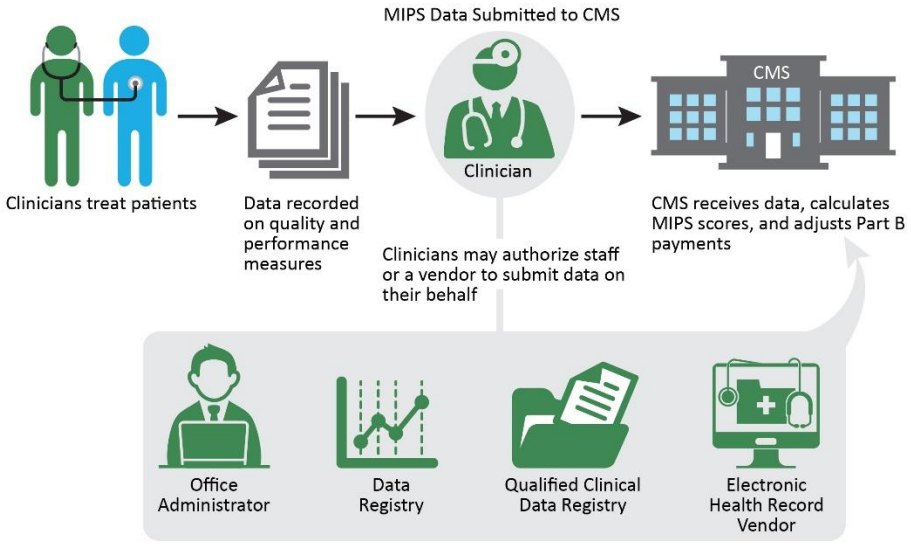
Merit-Based Incentive Payment System. Using the Physician Fee Schedule as a base rate, MIPS will adjust clinicians' Medicare Part B payments up or down based on their performance in four categories:

- quality,
- advancing care information,
- improvement activities, and
- cost.[11, 12]

Within each category, CMS has defined a set of possible measures or activities. For the first three categories, clinicians select from a menu of CMS-approved measures and must report data to CMS annually. For the Cost category, CMS calculates certain measures based on claims data. As described below in Exhibit 2, clinicians may use a variety of options to report these data (e.g., claims data, electronic health records, and qualified clinical data registries). Additionally, clinicians may report individually or as part of a group, and they may use vendors or authorized staff (e.g., data registries or the administrator of a group practice) to submit MIPS data on their behalf.

For each clinician, CMS calculates a MIPS final score based on the clinician's performance across the categories during a designated time period, or "performance period," during the calendar year.[13] CMS uses clinicians' MIPS scores for a given year to adjust Medicare Part B payments 2 years later. For example, CMS will use scores for 2017 (the first year for which CMS will assess performance under the QPP) to adjust payments in 2019. To determine payment adjustments, CMS compares each clinician's MIPS score to a "performance threshold" and increases or decreases that clinician's Part B payments accordingly. (See Appendix A for further detail about MIPS scoring.)

Exhibit 2. Submission of MIPS Data



Source: OIG analysis of CMS's implementation of QPP, 2017.
Note: Qualified clinical data registries are distinct from regular data registries because they are not limited to submitting MIPS measures. Qualified clinical data registries are permitted to submit alternative measures that, subject to CMS review and approval, will count towards the MIPS score.

For the 2017 performance period, clinicians are generally exempted from MIPS reporting requirements if they:

(1) meet the "low-volume threshold" of having no more than $30,000 in Medicare Part B charges or no more than 100 Part-B enrolled Medicare beneficiaries during the performance period[14];
(2) enroll in Medicare for the first time; or
(3) meet criteria for participation in the Advanced APM track (see below).[15]

CMS estimates that between 592,119 and 642,119 clinicians are eligible to participate in MIPS for the 2017 performance year.

CMS has designated 2017 as a transition year in which clinicians may "pick their pace" for reporting MIPS data.[16] Clinicians who are subject to MIPS may elect one of the reporting options outlined in Exhibit 3. During the first performance period, CMS will not negatively adjust payments if clinicians submit a minimum amount of data to CMS. Clinicians who submit more measures or data for the full year will be eligible for positive payment adjustments.

Exhibit 3. "Pick Your Pace" Options To Report MIPS Data for the First Performance Year

Pace	Reporting Period	Payment Adjustment
Submit Nothing	Clinician does not submit any data to CMS	Negative 4-percent payment adjustment
Submit Something	Clinician reports a minimum amount of 2017 data to CMS	No payment adjustment
Submit a Partial Year	Clinician reports data for a 90-day period in 2017 to CMS	Either no payment adjustment or a positive adjustment, depending on the data submitted
Submit a Full Year	Clinician reports data for the full year (2017) to CMS	Eligible for a positive payment adjustment

Source: CMS, *Quality Payment Program: Pick Your Pace in MIPS*, from https://qpp.cms.gov/.

Advanced APMs. MACRA established criteria for designating certain payment and care delivery models as Advanced APMs.[17] See Appendix B for the list of the programs designated as Advanced APMs for the first performance period. These models are designed to financially reward high-quality and cost-efficient care. Clinicians with a certain proportion of their Medicare Part B patients or payments received through an Advanced APM are deemed "Qualifying APM Participants." These clinicians are exempt from MIPS reporting and are instead subject to a different set of incentive payments. Specifically, Qualifying APM Participants will receive a 5-percent annual bonus during payment years 2019 through 2024; beginning in 2026, Qualifying APM Participants will receive higher physician fee-schedule updates.

IT Systems To Support the QPP

Building the IT systems to support the QPP is a significant undertaking for CMS, requiring both public-facing products (e.g., an interface for data submission) and back-end systems (e.g., a module to calculate MIPS final scores). Further, these complex systems must be completed on schedule so that key elements of the program, such as data submission, can occur according to the timeframe specified in statute and regulation. The IT systems for the QPP encompass the following six products:

- The **platform** is the infrastructure that underlies and supports all of the other QPP products. It ensures that various development efforts are coordinated and employ common methods.
- The **website** is the central site where all clinicians, their partners, and developers interested in interacting with the QPP come to perform tasks. Ultimately, it will include both public webpages with general information and other pages where individual users can access secure, authenticated accounts providing QPP performance information.
- The **eligibility product** uses CMS data sources to determine clinicians' eligibility for the QPP (i.e., whether they are required to participate to avoid a negative payment adjustment), including whether they are qualified to participate under the MIPS track or the Advanced APM track.
- The **data submission product** enables clinicians, as well as other staff or vendors authorized to provide data on their behalf (e.g., office administrators, registries), to submit MIPS data to CMS. CMS will support a variety of submission mechanisms.
- The **scoring product** will enable CMS to calculate each clinician's final MIPS score based on the data submitted. These scores will also be used to determine the payment adjustment that each MIPS clinician will receive in 2019.
- The **feedback product** will produce individualized reports providing clinicians with information about their performance, including their respective final MIPS scores and payment adjustments.

As OIG reported in our previous review, the QPP website was launched in October 2016. Additionally, eligibility determinations were made available to clinicians beginning in April 2017. The remaining products were still under development as of fall 2017.

Clinician Readiness

According to CMS staff, clinicians' acceptance of the QPP and readiness to participate are critical to the program's success. However, stakeholders have expressed concerns about whether providers—especially solo, small-practice, and rural providers—will be technically and logistically ready to participate in the QPP. Clinicians will require information and support from CMS for three key activities during 2017, as described below:

Determining the appropriate QPP track. Clinicians need to determine whether they are eligible for the MIPS or the Advanced APMs track—or, alternatively, whether they are exempted from participation altogether (for example, if they are under the low-volume threshold).

Selecting measures and collecting data. For the 2017 performance year, MIPS-participating clinicians must choose from an array of 271 Quality measures,[18] 15 Advancing Care Information measures,[19] and 92 Improvement activities.[20] Clinicians need to select the combination of measures and activities best suited to their respective practices while also meeting MIPS reporting requirements. They must also decide whether they will participate in MIPS as individuals or as part of a group and which reporting mechanism (e.g., data registries, electronic health record (EHR) vendors) will best fit their needs. Qualifying APM Participants do not need to select MIPS measures.

Submitting data to CMS. MIPS-participating clinicians must report their performance data to CMS by March 31, 2018. Qualifying APM Participants do not need to report any additional QPP data to CMS.[21]

To assist clinicians with these tasks, CMS has sponsored outreach events and awarded contracts under a variety of technical assistance programs.[22] Technical assistance contractors are responsible for providing customized education, support, and assistance that is appropriate to each clinician and practice type. Effective and timely technical assistance may also help reduce the burden on clinicians as they navigate the new program.

TIMELINE

The performance periods for MIPS and for Advanced APMs are broadly aligned with each other. For both, the first performance period began on January 1, 2017. Clinicians—or their authorized staff—have from January 1, 2018, through March 31, 2018, to report their 2017 performance data to CMS. Using the data submitted, CMS will calculate final MIPS scores and provide performance feedback to clinicians in July 2018. MIPS payment adjustments and Advanced APM bonuses based on 2017 performance will go into effect in 2019. The QPP will operate on an overlapping 3-year program cycle. The first year of each cycle is the performance period; the second year is for reporting data and calculating scores; and the third year is for adjusting payment. (See Appendix C.)

METHODOLOGY

To describe CMS's progress in mitigating the vulnerabilities that OIG identified in our 2016 report and to identify emerging challenges, we interviewed CMS staff and reviewed relevant internal CMS documents as well as publicly available information.

Scope. This review describes CMS's activities to implement the QPP. We did not review other HHS operating divisions or staff divisions involved in QPP operations, such as the Assistant Secretary for Planning and Evaluation. Our review primarily describes CMS's activities through fall 2017.

Interviews. We interviewed CMS staff between July 2017 and September 2017. For each of the vulnerabilities that OIG identified in last year's report (IT system completion and clinician readiness), we asked about CMS's current priorities; progress to date; the timeline for remaining activities; roles and responsibilities; communication; and challenges. Additionally, we asked CMS officials to identify any emerging risks to QPP implementation. Finally, we interviewed CMS staff regarding the agency's activities to ensure adequate oversight and program integrity for the QPP, and we requested followup information in writing.

Documents. We requested and received from CMS a variety of documents related to its QPP implementation efforts. These included, but are not limited to, materials on operations and management activities; communications and outreach activities; technical assistance and training activities; IT development activities; and QPP organizational structures. We also reviewed publicly available information, such as CMS training and technical assistance materials; resource tools for developers; and program guidance documents.

Analysis. We conducted a qualitative analysis of interview responses, CMS documents, and publicly available information to identify key milestones (both those achieved and those yet to come), priorities, and challenges related to developing IT systems and fostering clinician readiness.

To identify emerging challenges, we conducted a qualitative analysis of interview transcripts and documentation to determine whether additional challenges were (a) directly described or (b) suggested by gaps in the initial information CMS provided. Following this analysis, we requested an additional interview and written information specific to CMS's program integrity efforts related to the QPP, which we then reviewed to determine the extent to which the agency has planned and/or undertaken QPP oversight activities.

To identify vulnerabilities, we reviewed priorities and milestones yet to be achieved and identified those that both (a) will require extensive, sustained CMS activity in 2018 to address and (b) pose a significant risk to the QPP's success if insufficiently addressed.

Limitations. Our review focused on CMS's management of the QPP's implementation during the first performance year. At this point in the program's development, we did not assess the extent to which CMS's management of the QPP, or the QPP itself, will be successful in meeting program requirements and goals. Our review relied on self-reported information from a purposively selected sample of CMS staff involved in QPP implementation. We did not interview all CMS staff involved in the QPP, nor did we interview any contractors or external entities (e.g., clinicians participating in user testing). We reviewed a selective set of CMS documents that we requested based on their relevance to our study objectives.

With regard to IT security and functionality testing, OIG did not conduct an independent evaluation or audit of the QPP IT systems. The information reported here is based on interviews with CMS officials involved in IT development and testing as well as on documentation about testing results that CMS provided to OIG.

Standards. This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

COMPLETING IT SYSTEMS TO SUPPORT CRITICAL QPP FUNCTIONS

STATUS: CMS has made significant progress developing the IT systems necessary to support the QPP. CMS appears on track to deploy the systems needed for submission of MIPS data by January 1, 2018. During 2018, CMS will need to finalize clinicians' MIPS scores, provide them with feedback on their performance, and calculate their 2019 payment adjustments.

WHAT'S BEEN DONE

- ✓ *Platform* – Developed a consistent approach and a flexible, scalable infrastructure
- ✓ *Website* – Added new content and functionality to public QPP website
- ✓ *Eligibility* – Developed and deployed IT products to make QPP eligibility determinations
- ✓ *Data submission* – Tested, but has not fully deployed, applications to support submission of MIPS data
- ✓ *Scoring* – Tested, but has not yet deployed, real-time scoring

WHAT'S STILL TO COME

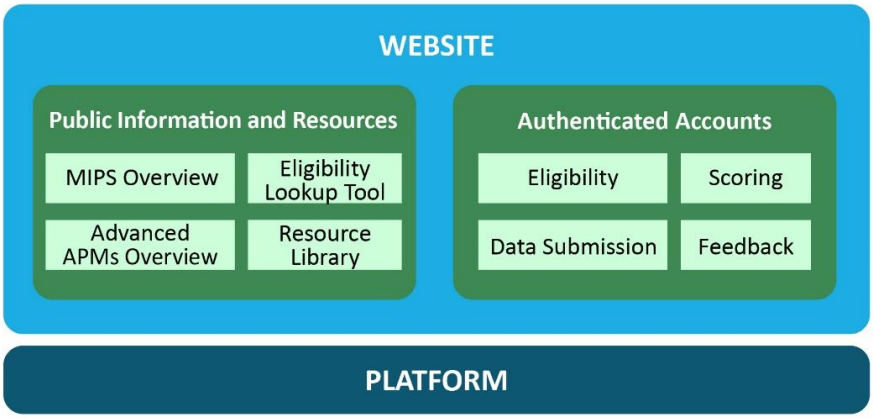
- *Platform* – Complete security testing of new QPP functions and maintain ongoing security monitoring
- *Website* – Add authenticated accounts by January 1, 2018
- *Eligibility* – Make final determinations of eligibility
- *Data submission* – Finalize and release data submission applications by January 1, 2018
- *Scoring* – Fully score data submitted by clinicians and calculate payment adjustments
- *Feedback* – Provide clinicians with feedback on their MIPS performance in July 2018

OVERVIEW

The IT systems for the QPP encompass six products: platform, website, eligibility, data submission, scoring, and feedback. As depicted in Exhibit 4 on the following page, the platform is the infrastructure that provides the fundamental support for all QPP products and ensures a consistent approach to IT development and deployment across the program. The QPP website is the main conduit for all public-facing QPP IT functions and will include both a public site with general program resources and an authenticated account site where clinicians can access individualized QPP participation information. The public site includes overviews of the MIPS and Advanced APM tracks, a resource library, and a tool where clinicians can look up their QPP eligibility status. The authenticated account site will ultimately include capabilities for clinicians, and their authorized staff, to learn more about their eligibility status, submit MIPS data, receive a preliminary score after submitting data, and receive performance feedback about their final MIPS score and associated payment adjustment.

Overall, IT development appears on track to deploy all products necessary for data submission to begin on January 1, 2018. Below, we describe the status of the six QPP products as of August 2017. We also describe CMS's plans for developing additional QPP IT capabilities.

Exhibit 4. Relationship Among the QPP IT Products



Source: OIG analysis of CMS's implementation of QPP, 2017.

WHAT'S BEEN DONE

Platform – Developed a consistent approach and a flexible, scalable infrastructure. CMS has continued to use the agile development methods it adopted last year to build, test, and deploy IT products for the QPP. Agile development is an iterative approach[23] that provides the IT team with frequent opportunities to adjust priorities, conduct testing, respond to user feedback, and add new functionalities. Additionally, CMS requires all teams to use open-source products to share and test code as it is developed. CMS staff said that requiring the same tools and methods across the QPP IT teams will ensure that the separately developed products are consistent and can be integrated. CMS staff also reported that the iterative process has enabled them to respond quickly to policy changes that necessitate coding changes, because the infrastructure is in place to quickly test and then deploy revised code.

CMS staff reported that CMS has also adopted an iterative approach to functionality and security testing for the QPP so that testing occurs throughout the IT development process. OIG has not independently evaluated the IT security of QPP products. However, CMS provided documentation indicating that it had conducted functionality and security testing throughout the IT development process, including a Security Impact Analysis whenever significant new functions were introduced. Additionally, CMS staff reported that the testing team uses multiple analysis tools to test all new code for potential security flaws, and that new code is subject both to automated functionality testing, as well as "user story" tests in which the team assesses how the website functions for a typical user in certain scenarios.

> *"In historical terms, there was always concern with what you will find [during the] late stages of development. Doing [testing in an iterative] fashion relieves a lot of that anxiety. You will have already found the problems along the way and have already resolved them."* – CMS official

CMS also provided documentation indicating that, as of August, its functionality tests had primarily revealed defects rated as "minor." Few defects were determined by CMS to be "critical" or "major," and CMS staff reported that these problems had been addressed. Similarly, CMS provided documents indicating that potential security problems identified during testing had been resolved.

Finally, CMS said that to provide flexibility, it designed the QPP IT platform to rely on cloud computing through Amazon Web Services rather than the traditional "server room" used for prior IT initiatives. Under this approach, capacity is scalable and can be purchased as needed, enabling CMS to boost capacity during high-demand periods, such as upcoming submissions of MIPS data, and then reduce capacity when it is no longer needed.

Website – Added new content and functionality to public QPP website. CMS launched the QPP website on October 14, 2016. During 2017, CMS added new content and functionalities such as technical assistance resources, guides to MIPS measures applicable to particular specialties, and lists of CMS-approved vendors for data submission. CMS staff reported that as the IT team develops new website features, it continues to conduct user research to gather feedback and identify areas for improvement.

Eligibility – Developed tools to determine clinicians' QPP eligibility. To determine which clinicians are required to report MIPS data, CMS developed an eligibility-system component that compares data from Part B claims and the Provider Enrollment, Chain and Ownership System (PECOS)[24] to the criteria established in the MACRA statute and regulation.[25] In December 2016, CMS conducted an initial determination based on clinicians' claims from September 2015 through August 2016. CMS will repeat this analysis in December 2017 using claims from September 2016 through August 2017.

To identify clinicians eligible to participate in the Advanced APM track, CMS extracted Medicare claims data and information about participating clinicians from Advanced APMs' program records and manually compared those data with the Qualifying APM Participant criteria established in the QPP final rule for 2017.[26] CMS used this process to take three "snapshots" (on March 31, June 30, and August 31) to assess eligibility for the Advanced APM track. In October, CMS publicly released a tool that clinicians can use to look up whether they attained Qualifying APM Participant status based on the snapshot data.

Data submission – Tested, but has not fully deployed, applications to support submissions of MIPS data. In developing the data submission product, CMS staff reported that the agency is seeking to improve upon clinicians' negative experiences with its previous quality reporting programs. Specifically, clinicians expressed concerns that under prior programs, they had no way of knowing after submitting data whether they had done so correctly. Additionally, clinicians noted that the format they were required to use was labor-intensive.

To address these concerns, CMS is including automated data validation checks in the MIPS data submission system that is under development. This system is intended to provide clinicians and vendors with immediate feedback if the files they upload do not pass the data validation checks, and will allow them to resubmit data files during the data submission period (January 1 to March 31, 2018). Additionally, CMS intends to provide clinicians with a range of formats and options for submitting data. (See Appendix D.)

> *"The validation process looks at the general file format and . . . things that don't make sense mathematically. And before the user gets out of the session, they can know whether they need to fix something. . . . This is a huge improvement over how things were validated in the legacy applications."* – CMS official

In addition to supporting a variety of data submission formats, CMS is encouraging the use of new Application

Program Interfaces (APIs) developed this year. APIs are a method for data submission that allow machine-to-machine communication. Through APIs, software developers—such as registries and electronic health record vendors—can retrieve data directly for use in the developers' own applications. This provides additional options and convenience to clinicians, and also facilitates efficient handling during high-volume submission periods. To assist vendors, CMS made the APIs for MIPS data submission available for developers to test beginning in July 2017. As of late August 2017, over 100 vendor organizations were participating in the API testing.

Scoring – Tested, but has not yet deployed, real-time preliminary scoring. CMS has developed infrastructure to support real-time scoring so that clinicians can view their respective MIPS scores as soon as their data is submitted. The preliminary score is intended to provide immediate feedback on how a clinician performed in each MIPS category (Quality, Improvement Activities, and Advancing Care Information).[27]

WHAT'S STILL TO COME

Platform – Complete integration and security testing of new QPP functions and maintain ongoing security monitoring. As the first submission period approaches, CMS plans to continue and complete integration testing of all products being deployed. CMS must also complete security testing of the eligibility, submission, and scoring products, which was planned for mid-November 2017. Once these QPP IT products are deployed, CMS must conduct ongoing security monitoring to ensure that these functions continue operating securely and reliably.

Website – Deploy authenticated accounts by January 1, 2018. CMS must deploy secure, authenticated accounts no later than the beginning of the data submission period on January 1, 2018. MIPS-eligible clinicians require authenticated QPP accounts to submit MIPS data, to receive a preliminary score after data submission, and to receive performance feedback reports about their final score and associated payment adjustment. Clinicians will also use authenticated accounts to indicate which staff and vendors (e.g., EHRs and registries) are authorized to submit MIPS data on their behalf. Once designated by a clinician, authorized staff and vendors must also obtain authenticated accounts before accessing the systems for QPP data submission and feedback. CMS is currently attempting to integrate the login information that clinicians use to access their existing accounts under CMS's legacy systems into each clinician's new QPP account. It plans to deploy authenticated QPP accounts in December 2017.

> *"We have to support base function in year one, but the pipe dream is having a user coming from [other CMS systems] and then reusing their existing authorization to access QPP in a way that minimizes their burden."* – CMS official

Eligibility – Make final eligibility determinations. In December 2017, CMS plans to re-run its earlier eligibility analyses to make final determinations as to which clinicians are required to report MIPS data, which are Qualifying APM Participants, and which are exempt for 2017. Additionally, for the Advanced APM track, CMS is developing an IT application (the APM Management System) to automate Qualifying APM Participant determinations. CMS staff reported that as of October 2017, the APM Management System had passed all necessary security testing and was expected to be finalized in fall 2017.

Data submission – Finalize and release data submission applications by January 1, 2018. CMS needs to complete its testing of the applications for submission of MIPS data and fully deploy the final

versions no later than January 1, 2018, when the first data submission period begins. CMS staff reported that as of November 2017, the data submission product was on track to meet this deadline.

Scoring – Fully score data submitted by clinicians and calculate payment adjustments. CMS needs to complete and deploy the real-time, preliminary scoring function when the data submission period begins. By the end of the data submission period on March 31, 2018, CMS will need to have finalized the IT product to calculate the final MIPS scores. In spring 2018, CMS will also need to finalize and implement the process for calculating the payment adjustments associated with final MIPS scores. CMS staff reported that as of July 2017, the scoring product was on track to meet these deadlines.

Feedback – Provide clinicians with feedback on their MIPS performance during summer 2018. During summer 2018, CMS must provide MIPS-eligible clinicians with feedback on their individual performance and the associated payment adjustment they will receive in 2019. During 2017, CMS prepared for this by conducting user testing to better understand the types of performance feedback that would be most useful to clinicians and clinicians' preferences for displaying that information in feedback reports. During spring 2018, CMS must finalize the format and functionality for the performance feedback reports, so that these reports are ready to compile and distribute in July 2018.

ENSURING CLINICIAN READINESS TO PARTICIPATE IN THE QPP

STATUS: CMS has directed an extensive campaign to raise clinicians' awareness of the QPP, including providing education and assistance; communicating eligibility determinations; and establishing a Service Center. CMS has stated that as implementation continues, it will place increased focus on specialized technical assistance to meet practice-specific needs.

WHAT'S BEEN DONE

- ✓ Conducted an outreach campaign to raise clinician awareness of the QPP
- ✓ Provided technical assistance to clinicians and practices to assist with QPP preparedness
- ✓ Communicated clinicians' initial QPP eligibility determinations
- ✓ Issued subregulatory guidance
- ✓ Established a Service Center to respond to questions and refer clinicians to technical assistance contractors

WHAT'S STILL TO COME

- Continue outreach activities to maximize clinician awareness and understanding
- Increase focus on specialized technical assistance to support successful participation

VULNERABILITY:

- If clinicians do not receive sufficient information and assistance, they may struggle to succeed under the QPP or choose not to participate. This is of particular concern for small practices and clinicians in rural or medically underserved areas, who may lack the resources to fully engage in the QPP without customized technical assistance to meet practice-specific needs.

OVERVIEW

Since the QPP's inception, CMS officials have consistently stated that clinicians' acceptance of and readiness to participate is crucial to the program's success. For 2017—the program's first performance period—CMS set a goal of 90 percent participation in QPP. To reach this goal, CMS has used multiple channels to educate clinicians, provide technical assistance, and collect feedback. For example, CMS held numerous webinars and other events; issued subregulatory guidance; and established a Service Center to respond to questions and resolve problems. CMS also awarded a variety of contracts to provide technical assistance specific to clinicians' practice types and needs.

> *"We started with a baseline of zero—no one had knowledge about the program, and we had a short time to bring physicians up to speed. Now, we have everyone talking about QPP."* – CMS official

Through these efforts, CMS has raised awareness of the QPP, and a majority of eligible clinicians have reported to CMS that they intend to participate. CMS staff said that because the QPP was an entirely new initiative, it was necessary for early outreach efforts to focus on general education and awareness. However, CMS staff report that as QPP implementation continues, a greater focus on specialized, practice-specific technical assistance will be needed to help clinicians fully participate in the new program.

WHAT'S BEEN DONE

Conducted an outreach campaign to educate clinicians about the QPP. As of September 2017, CMS and its cosponsors had reached an estimated 176,000 people (including clinicians, practice managers, vendors, and other audiences) through a total of 631 outreach events. These included nationally available webinars, speeches at medical association meetings, in-person regionally based trainings, "town hall" listening sessions, and other educational events. Of the 405 events for which detailed information was available at the time of our analysis, approximately one-quarter were targeted to clinicians in rural areas.

As part of its communications strategy, CMS has coordinated with stakeholders such as professional associations, vendors, the Rural Health Association, and clinician groups. CMS also entered into a variety of cobranding arrangements for education and training delivery, partnering with organizations such as medical associations,[28] so that clinicians can turn to a trusted source and receive consistent messages. Finally, CMS has continued to work with 12 "Clinician Champions" who provide CMS with clinician perspectives while also sharing information about the QPP among their peers.

> *"We know providers can speak better to providers, so we capitalize on peer-to-peer communications."*
> – CMS official

A CMS tracking survey conducted in spring 2017 demonstrates both progress and the need for continued outreach. The survey found high levels of awareness (71 percent) among practice managers, but lower levels of awareness among clinicians and midlevel practitioners (60 percent and 44 percent, respectively). Respondents indicated substantial confusion regarding the Advanced APM track versus the MIPS track. Overall, 63 percent reported intending to participate in 2017. While these numbers have likely increased, it remains to be seen whether CMS's goal of 90 percent participation can be achieved. CMS officials indicated that the agency will repeat the tracking surveys semiannually to continue to assess clinician awareness.

Provided specialized technical assistance to clinicians and practices. To succeed under the QPP, clinicians must—at minimum—understand the program requirements and how to report performance data. Because the QPP is designed to reward high-quality, high-value care, the program may also lead providers to implement changes to their clinical practices to increase focus on quality and care coordination. Specialized technical assistance can help clinicians understand how to select measures; develop and implement MIPS score improvement plans; select EHR vendors; and other tasks.

To address the needs of different practices, CMS established three technical assistance groups that are charged with assisting specific types of clinicians and practices. Eleven QPP Small, Underserved, and Rural Support (QPP-SURS) contractors serve small practices and clinicians located in rural and medically underserved areas. Additionally, 14 Quality Innovation Networks-Quality Improvement Organizations (QIN-QIOs) provide QPP assistance to large practices, i.e., those with 15 or more clinicians. Finally, 41 Transforming Clinical Practice Initiative (TCPI) cooperative agreement grantees help clinicians to modify their practices in ways that align with MIPS incentives and to prepare for eventual adoption of alternative payment models. In addition to providing education and assistance, these three groups of technical assistance providers also serve as a key source of feedback to CMS, relaying the questions and concerns they hear from clinicians.

CMS officials stated that as of July 2017, QPP-SURS and QIN-QIO contractors had devoted the majority of their efforts to broadly targeted outreach geared towards general awareness and education, while

25 to 30 percent of these contractors' efforts were devoted to more specialized technical assistance focusing on practice-specific needs. Differences in definitions, timeframes, and reporting formats over time and among contractor types make it difficult to quantify the proportion of clinicians who have received assistance. Generally, contractors report the number of clinicians they have engaged through a range of activities, including online tools, webinars, and direct assistance (e.g., conducting technology assessments, supporting clinicians' EHR use, and responding to questions). Some of these activities are targeted to individual practices, while others are directed to small groups or a broader audience. The overall estimate of how many clinicians have been reached by each contractor group is summarized below.

- QPP-SURS contractors reported having provided technical assistance to approximately 67,000 clinicians as of August 31, 2017. This constitutes 37 percent of the total number of eligible clinicians in these contractors' jurisdictions. The small and rural practices served by QPP-SURS contractors are the population most likely to require support.
- QIN-QIO contractors report monthly numbers rather than an unduplicated cumulative total of clinicians served. During August 2017, the most recent month with data available, contractors reported providing technical assistance to approximately 120,000 clinicians. This was slightly higher than the numbers reported for July (approximately 96,000 clinicians) and June (approximately 84,000 clinicians). At the time of our review, the total number of eligible clinicians in all QIN-QIO jurisdictions was not available.
- TCPI grantees do not report their numbers of technical assistance contacts; however, nearly all reported having a defined technical assistance program to prepare clinicians for QPP participation. TCPI grantees described a variety of individualized technical assistance activities serving that goal, including troubleshooting EHR issues; working with clinicians to ensure that they correctly enter and validate data; and helping to develop and connect advanced practices to appropriate APMs.

Communicated clinicians' initial QPP eligibility determinations. In the preamble to the QPP final rule for 2017, CMS indicated its intention to communicate MIPS eligibility information in December 2016. However, CMS did not begin to notify clinicians of MIPS eligibility until April 2017, a delay that raised concern among some stakeholders. In May, CMS added an eligibility lookup tool to the QPP website; clinicians can use the tool at any time to receive individualized information about their MIPS eligibility status. Clinicians who had questions about their MIPS eligibility or disagreed with the information provided by CMS were directed to contact the QPP Service Center. CMS documents indicate that from June through August 2017, questions about MIPS eligibility were the largest source of inquiries to the Service Center.

> *"[W]hat is powerful about [the eligibility lookup tool] is that it allows people to understand what is required of them [individually]. We took hundreds of pages of regulation and put it into one interface."* – CMS official

In June 2017, CMS also notified clinicians as to whether they were likely to meet the threshold for Qualifying APM Participant for 2017. Additionally, a Qualifying APM Participant lookup tool is available on the QPP website. CMS staff reported receiving few questions from clinicians about their predicted Qualifying APM Participant status.

Issued subregulatory guidance. CMS issued subregulatory guidance on a variety of key issues, including group reporting options; data submission and reporting; data validation and auditing; MIPS measures; MIPS scoring; and APMs. All guidance is publicly available through the QPP Resource Library.

Established a Service Center to respond to questions and refer clinicians to technical assistance contractors. CMS established a Service Center, accessible by phone or email, to answer questions about the QPP and refer clinicians to the appropriate technical assistance contractors. CMS reported that as of late September 2017, the Service Center had received more than 47,500 inquiries from more than 27,000 unique users in 2017.

> *"Every person that calls [the Service Center] is offered the opportunity to get additional technical assistance."* – CMS official

CMS reported that 82 percent of all inquiries were resolved during the first contact with the Service Center. In many cases (56 percent of all inquiries), the resolution included referral to a technical assistance contractor. Technical assistance contractors reported to CMS that they typically made contact with their referrals within 24 hours. Overall, callers reported a high degree of satisfaction with their Service Center experience; when surveyed by CMS, more than 90 percent indicated that their concerns were satisfactorily addressed.

The Service Center also serves as a key source of clinician feedback, alerting CMS to potential problems and identifying common areas of confusion or misunderstanding. For example, CMS reported that the initial notification letters sent to clinicians incorrectly identified some physical therapists as being eligible for MIPS, when in fact physical therapists are excluded. A provider called the Service Center about the issue, and the Service Center immediately informed the IT team. The IT team identified and fixed the source of the error, ensuring that clinicians using the eligibility lookup tool would now receive correct information. Finally, CMS's Communications team worked with partners in the physical therapy community to inform them of the issue as well as the corrected information. According to CMS, the entire incident took fewer than 72 hours to resolve.

WHAT'S STILL TO COME

Continue outreach activities to maximize clinician awareness and understanding of the QPP. CMS reported that to ensure that all clinicians are aware of the QPP and understand what it requires, CMS will continue to conduct extensive outreach. Although CMS officials described its technical assistance contractors as being "on track" to meet their goal of engaging all eligible clinicians in their regions by the end of 2017, data from contractors' monthly reports suggest that there is significant variation among the contractors responsible for different geographic regions. For example, as of August 31, 2017, some contractors reported having engaged nearly all providers in their jurisdictions while others reported having engaged less than one-quarter. Further, Service Center data indicate that clinicians continue to have questions about both eligibility and scoring criteria, and that small practices, in particular, need information and assistance.

Increase focus on specialized technical assistance to support successful QPP participation. To date, CMS has emphasized general education and outreach to raise awareness of the QPP. However, officials stated that the balance of effort should shift towards more specialized technical assistance as the program enters its second year. Such practice-specific technical assistance is likely to be especially important to small and rural clinicians, who CMS has anticipated may require help with clinical quality measurement, change management, practice workflow redesign, EHR vendor selection, and other issues.

> *"The tone and tenor of the types of questions the contractors are receiving will change from 'What is this?' to 'How do I do it?' So, [the amount] of hands-on, customized technical assistance [provided by contractors] is likely going to increase as clinicians move beyond their initial awareness of the program."* – CMS official

VULNERABILITY: IF CLINICIANS DO NOT RECEIVE SUFFICIENT TECHNICAL ASSISTANCE, THEY MAY STRUGGLE TO SUCCEED UNDER THE QPP OR CHOOSE NOT TO PARTICIPATE

Clinician feedback collected by CMS demonstrates widespread basic awareness of the QPP, but also indicates uncertainty regarding details of participation such as who must report and how to submit data. Further, to date, CMS contractors have focused largely on general education initiatives, with fewer resources devoted to more customized, practice-specific technical assistance. CMS needs to continue to assess progress and increase the proportion of contractors' efforts devoted to specialized technical assistance to support high levels of clinician participation. Small practices and clinicians in rural or medically underserved areas, who may have fewer administrative resources and less experience with prior CMS quality programs, should be prioritized for assistance.

EMERGING ISSUE: ENSURING ADEQUATE OVERSIGHT AND PROGRAM INTEGRITY

STATUS: CMS has not yet developed a comprehensive program-integrity plan for the QPP. Appropriate oversight, particularly to ensure the accuracy of MIPS data, is critical to prevent fraud and improper payment adjustments.

WHAT'S BEEN DONE

- ✓ Included oversight provisions in the QPP final rule for 2017
- ✓ Established oversight process for CMS-approved vendors

WHAT'S STILL TO COME

- Clearly designate leadership responsibility for QPP program integrity
- Develop and implement a comprehensive QPP program integrity plan that addresses:
  - potential vulnerabilities in the MIPS data submission system and
  - the accuracy of MIPS data submitted by clinicians, particularly the self-attestation measures

VULNERABILITY:

- If CMS does not develop and implement a comprehensive program integrity plan for the QPP, the program will be at greater risk of fraud and improper payments.

OVERVIEW

In addition to assessing CMS's progress in addressing the two vulnerabilities that we identified in our 2016 review—completing IT systems and ensuring provider readiness), we also sought to identify any emerging challenges or risks to the program. From our interviews with CMS staff and our reviews of program documents, we identified a critical management issue: delays in adequately planning for QPP program integrity. We found that CMS has not yet developed a comprehensive plan for QPP program integrity, nor has the agency clearly designated roles and responsibilities for oversight of the program.

Appropriate oversight, particularly to ensure the accuracy of MIPS data, is crucial to prevent fraud and improper payments. Specifically, if the data that clinicians submit do not accurately represent their performance, they may inappropriately receive positive or negative payment adjustments. Below, we describe CMS's efforts to date and identify key issues that remain to be addressed.

WHAT'S BEEN DONE

Included oversight provisions in the QPP final rule. In the final rule for 2017, CMS included program integrity provisions for both the MIPS track and the Advanced APM track. In terms of the MIPS track, the rule addressed auditing and requirements for record retention. Specifically, according to the rule, CMS will selectively audit MIPS-eligible clinicians on a yearly basis and, if clinicians are selected for an audit, they must comply with requests for data-sharing and documents.[29] To support such audits, CMS required MIPS-eligible clinicians and groups to retain—for up to 10 years after the performance period—copies of medical records, charts, reports and any electronic data utilized to determine which measures and activities were applicable and appropriate for reporting under MIPS. If a MIPS-eligible

clinician or group is found to have submitted inaccurate data for MIPS, CMS indicated that it would reopen, revise, and recoup any resulting overpayments.

The QPP final rule for 2017 also included program integrity provisions applying to Advanced APMs. CMS will vet and monitor individuals and entities (e.g., clinician groups) participating in Advanced APMs as well as new applicants applying to participate.[30] The final rule indicated that if a clinician is out of compliance with program requirements, or is terminated by an Advanced APM for program integrity reasons, the agency may reduce or deny the APM payment incentive to that clinician. CMS also indicated that it would reopen and recoup any payments made in error.

Established oversight process for CMS-approved vendors. Because of the role of registries in gathering and reporting MIPS data on behalf of clinicians, CMS established an oversight process for registries. The process includes the following requirements: attestation that all data and results are accurate and complete; submission of a data validation report to CMS; and compliance with any CMS requests to review submitted data. If data inaccuracies affect more than 3 percent of a vendor's total MIPS-eligible clinicians, CMS may give that vendor a low rating for data quality on its listing of qualified registries and place it on probation. Data inaccuracies affecting more than 5 percent of a vendor's total MIPS-eligible clinicians could lead to the vendor's disqualification for the following year.

WHAT'S STILL TO COME

Clearly designate leadership responsibility for QPP program integrity. In discussing CMS's management approach to QPP implementation, CMS officials stressed the importance of assigning executive leaders for key aspects of the program, such as policy, communications, and IT development. However, CMS has not designated an individual as having leadership responsibility for QPP program integrity, although CMS noted that program integrity officials at various levels were present at biweekly QPP leadership meetings. In interviews and written responses, CMS communicated that program integrity planning and activities would be shared across multiple divisions, but was not able to delineate how responsibilities are divided. Additionally, CMS indicated that integrated project teams do not include staff dedicated to program integrity, although CMS noted that program integrity staff serve as a resource for the QPP teams and have collaborated on tasks such as provider authentication for the QPP website's authenticated accounts.

Develop and implement a comprehensive QPP program integrity plan. CMS needs to develop and implement a comprehensive program integrity plan. CMS staff reported that senior staff who manage the QPP and the agency's overall program integrity efforts are planning to meet in December 2017 to initiate development of an oversight plan for the QPP. CMS staff reported that they plan to use the Government Accountability Office's (GAO) Fraud Risk Management Framework as the basis for developing QPP oversight.[31] They anticipated addressing three main program integrity issues: (1) oversight of the eligibility and enrollment of clinicians; (2) ensuring proper payments, and (3) ensuring the validity of MIPS data.

> *"CMS is currently in the early stages of developing an oversight plan for QPP data."* – CMS correspondence to OIG

In addition to addressing the risks that CMS identifies as it applies the GAO Fraud Risk Management Framework to the QPP, the plan should address two particular issues that OIG identified during our review:

- potential vulnerabilities in the MIPS data submission system and
- the accuracy of MIPS data submitted by clinicians, particularly the self-attestation measures.

Potential vulnerabilities in the MIPS data submission system. The QPP IT system for data submission is intended to provide clinicians with real-time feedback about how the data they submit affects their MIPS score. This preliminary score will not indicate what level of payment adjustment the clinician will receive, but it is intended to provide immediate feedback on whether the clinician has earned the maximum points available. More points are likely to translate to a higher positive payment adjustment. In addition to providing real-time scoring, the submission system is also intended to permit users to resubmit data files that will supersede their prior submissions. This resubmission function is scheduled to be available during the open period for QPP data submission, i.e., January through March 2018.

The submission system's capabilities to provide real-time scoring and allow resubmissions were designed to provide clinicians with efficient feedback and the opportunity to correct data errors. However, these same functions make it possible for a user to "game" the submission system to obtain a higher MIPS score than the one to which the user is entitled, therefore potentially resulting in an improper positive payment adjustment. For example, to submit data on Advancing Care Information measures, clinicians will select a series of checkboxes to certify to their EHR use. Once the user completes the checklist, the system will provide a real-time score and indicate whether the clinician received the maximum points available. If users are not satisfied with their first score, the system will permit them to go back, complete the checklist again with different answers, and see how that affects their score. Although users may resubmit their data to obtain the highest score to which they are lawfully entitled, this same resubmission process could be abused if users submit inaccurate data solely for the purpose of obtaining the maximum possible points.

CMS staff confirmed that the data submission system will maintain multiple versions of submissions, making it possible for a reviewer to determine how and when clinicians change their data submissions. However, staff with expertise in program integrity were not consulted in the design of the system to ensure that data are collected and maintained in such a way as to facilitate oversight. Additionally, CMS does not yet have a program integrity plan in place to ensure that data submissions are reviewed for evidence of fraud.

Accuracy of MIPS data submitted by clinicians, particularly the self-attestation measures. To ensure proper MIPS payment adjustments, CMS must also ensure the accuracy and validity of data submitted by clinicians and their authorized staff. For the 2017 transition year, CMS indicated that its data validation efforts will focus on those clinicians who submitted fewer than the required number of quality measures and will determine whether the clinicians submitted all applicable measures for their specialty.[32] Additionally, CMS incorporated data validation functions into its data submission system, but these automated checks were designed only to identify incorrect file formats and quality-measure data that do not make sense (e.g., a reported quality measure where the numerator is larger than denominator). CMS's automated data validation processes cannot detect whether incorrect or falsified data are being submitted. Rather, CMS solely relies on the certification of either the clinicians or their authorized staff that they are submitting accurate data. To address this vulnerability, CMS's QPP program integrity plan needs to include a robust audit strategy to review the accuracy and validity of MIPS data, particularly the self-attestation measures.

In a prior report, OIG identified problems with the accuracy of the attestation data submitted by providers during the legacy EHR Meaningful Use program, which has been replaced by the Advancing Care Information category in MIPS.[33] Like the latter, the former required clinicians to self-attest to performing certain activities. OIG found that from May 2011 through June 2014, CMS paid an

estimated $729 million in Medicare EHR incentive payments to eligible professionals who did not comply with Federal requirements. OIG found that these errors occurred because providers did not maintain sufficient support for their attestations and because CMS conducted minimal documentation reviews of the self-attestations. OIG recommended that as CMS implements MACRA, it should include stronger program integrity safeguards that allow for more consistent verification of the reporting of required EHR measures. Without robust additional oversight, CMS's current process for validating Advancing Care Information attestation data seems likely to perpetuate the same problems found with the predecessor EHR program. In addition, the new MIPS reporting category on Improvement Activities is also based on self-attestation measures and may therefore also be vulnerable to fraud, abuse, or improper payments.

VULNERABILITY: IF CMS DOES NOT DEVELOP AND IMPLEMENT A COMPREHENSIVE QPP PROGRAM INTEGRITY PLAN, THE PROGRAM WILL BE AT GREATER RISK OF FRAUD AND IMPROPER PAYMENTS

To ensure that the QPP succeeds, CMS must effectively prevent, detect, and address fraud and improper payments. QPP payment adjustments are intended to reward high-value, high-quality care. Safeguarding the validity of MIPS data and the accuracy of QPP payment adjustments is critical to ensure that these payments are based on clinicians' actual performance.

Conclusion

OIG's previous review found that CMS had made significant progress towards implementing the QPP, but we also identified two potential vulnerabilities: completing IT systems and ensuring clinicians' readiness to participate in the QPP. In this followup review, we assessed CMS's progress in addressing these vulnerabilities and also sought to identify emerging challenges.

With respect to the first vulnerability, we found that CMS appears on track to deploy the IT systems needed for submission of MIPS data by January 1, 2018. CMS has continued to use the agile development methods it adopted last year, incorporating functionality and security testing throughout the process.

With respect to the second vulnerability, we found that CMS has carried out an extensive outreach campaign. However, thus far, the majority of efforts have been directed toward general awareness rather than specialized technical assistance designed to meet practice-specific needs. CMS staff indicated that as implementation continues, clinicians—particularly those in small or rural practices—will have a greater need for customized assistance to support successful QPP participation.

Additionally, we identified program integrity as an emerging challenge. The QPP relies on clinicians to submit their own performance data, including self-attestations. Providers may mistakenly submit inaccurate data, or could even potentially submit falsified data (for example, attesting to activities they did not perform) to receive a positive payment adjustment. Despite these risks, CMS has conducted minimal planning with regard to program integrity. Further, although CMS has designated executive leadership for other aspects of the QPP, it has not designated an executive lead on QPP program integrity. Without a comprehensive plan for program integrity, the QPP will be at heightened risk of fraud and improper payments, particularly related to MIPS payment adjustments.

If clinicians do not fully understand how to participate in the QPP, or if they lack the tools and support to make the practice changes necessary to respond to QPP incentives, the program may have limited success. Additionally, without adequate program integrity measures in place, the performance data submitted may not reflect the true cost or quality of care provided, similarly compromising the QPP's ability to achieve its goals.

OIG will continue to monitor CMS's progress in developing and operating the QPP and will conduct additional reviews as appropriate.

Appendix A

Overview of the MIPS Final Score for Performance Year 1, 2017

In the final rule for 2017, CMS finalized the proportion that each MIPS category will contribute to the final score.[34]

Quality:
60% in Year 1

- Measures: Clinicians must report on six measures or a defined set of specialty measures, which they may select from a variety of approved measures based on what is most applicable to their practice.
- Reporting: Clinicians may use a variety of options, including claims data, EHRs, and qualified clinical data registries.
- Predecessor program: Physician Quality Reporting System (PQRS)

Cost:
0% in Year 1

- Measures: Two overall cost measures: (1) per-capita costs for all attributed beneficiaries and (2) Medicare spending per beneficiary, as well as 10 episode-based cost measures, as applicable to the clinician
- Reporting: Via claims data, so there are no additional reporting requirements for clinicians
- Predecessor program: Value-Based Modifier (VBM) Program

Advancing Care Information:
25% in Year 1

- Measures: Five required measures with additional optional measures, focusing on interoperability and the use of EHR technology to support health care delivery
- Reporting: Clinicians may use a variety of options, including EHRs and qualified clinical data registries
- Predecessor program: Medicare EHR incentive program for eligible professionals

Improvement Activities:
15% in Year 1

- Improvement activities are designed to improve health care delivery, including care coordination, beneficiary engagement, population management, and health equity.
- CMS will annually publish an inventory list that will designate certain improvement activities as "high" or "medium" activities.
- Measures: Most clinicians attest that they completed up to four improvement activities for a minimum of 90 days.
- Reporting: Clinicians may use a variety of options, including attestation data, EHRs, and qualified clinical data registries.
- Predecessor program: None

Appendix B

Overview of Advanced APMs Available in the First QPP Performance Period

Shared Savings Program (Tracks 2 and 3)	•Shared Savings Program Accountable Care Organizations (ACOs) are composed of doctors, hospitals, and other health care providers and suppliers who are supposed to provide coordinated, high-quality care. •In Tracks 2 and 3, the ACO assumes risks for shared losses as well as for savings.* •Participants: 42 ACOs in Tracks 2 and 3 (as of October 2, 2017)
Next Generation Accountable Care Organization Model	•The Next Generation ACO Model allows provider groups to assume higher levels of financial risk and reward than are available under the current Shared Savings Program. •Participants: 44 ACOs (as of October 2, 2017)
Comprehensive End-Stage Renal Disease Care Model (LDO and two-sided risk tracks)	•Comprehensive End-Stage Renal Disease (ESRD) Care Model coordinates care for ESRD beneficiaries. •Two tracks have been determined to be Advanced APMs: (1) the large dialysis organization (LDO) arrangement and (2) the non-LDO two-sided risk arrangement. •In these two-sided risk arrangements, physician practices assume risks for losses as well as savings. •Participants: 37 ESRD model participants (as of October 2, 2017)
Comprehensive Primary Care Plus Model	•The Comprehensive Primary Care Plus Model focuses on regionally based multipayer payment reform and primary care delivery transformation. •CMS, commerical insurance plans, State Medicaid agencies, and other selected payer partners will align on payment, data sharing, and quality metrics. •Participants: 2850 primary care practices in 14 regions (as of October 2, 2017)
Oncology Care Model (Two-sided risk arrangement)	•In the Oncology Care Model, physician practices enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. •CMS is also partnering with commercial payers in the model. •Participants: 192 practices with 14 payers (as of October 2, 2017)
Comprehensive Care for Joint Replacement Model (Track 1)	•The Comprehensive Care for Joint Replacement model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and providers of post-acute care to work together to improve the quality and coordination of care from the initial hospitalization through recovery. •Participants: 67 geographic areas (as of October 2, 2017)

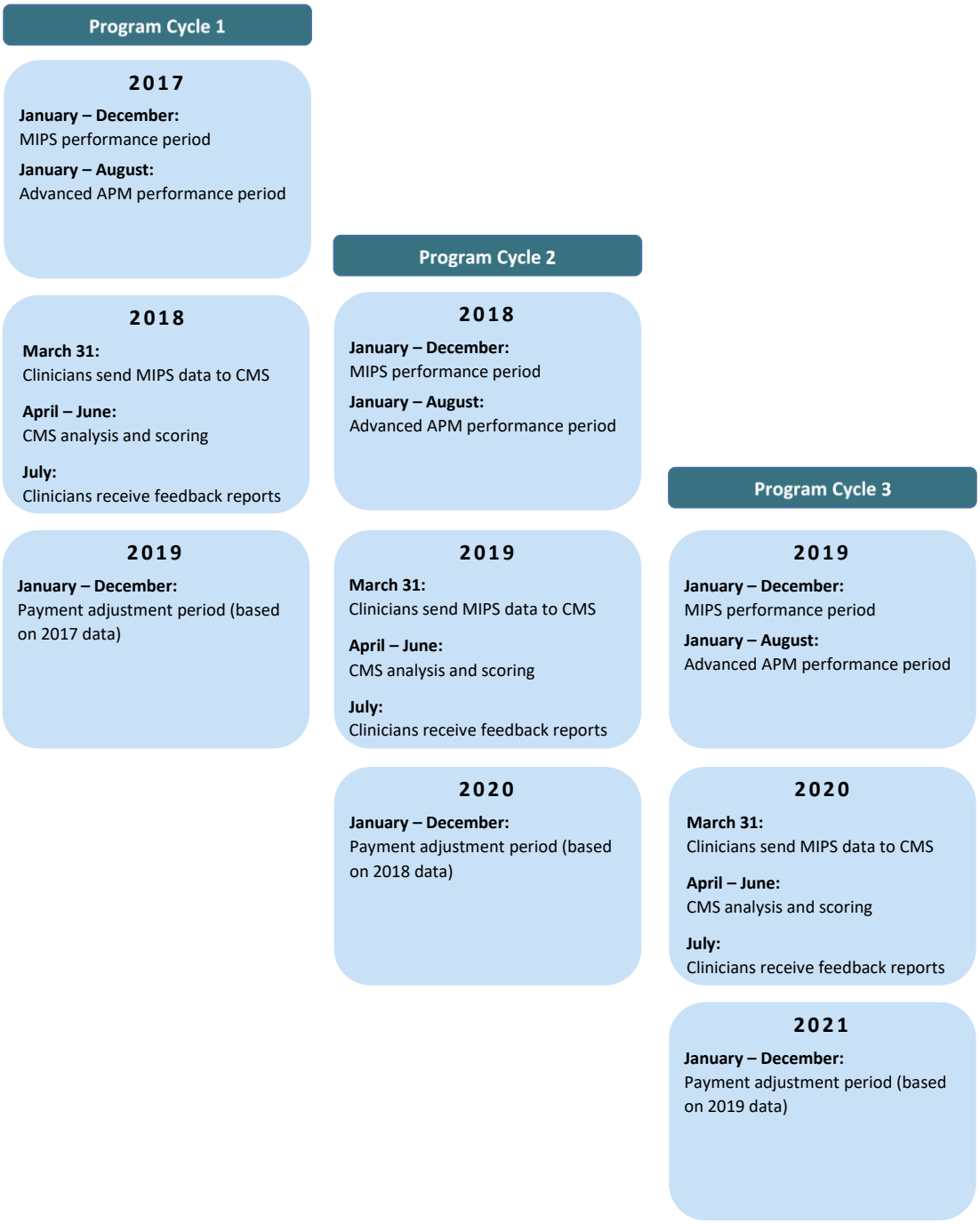
Source: OIG analysis of CMS's implementation of the QPP, 2017.

*In Track 1 of the Shared Savings Program, the ACOs share in program savings. Without requiring ACOs to also assume risk for losses, Track 1 does not meet the criteria to be an Advanced APM in the QPP. Because ACOs in Tracks 2 and 3 of the Shared Savings Program are required to assume risks for both savings and losses, Tracks 2 and 3 qualify as Advanced APMs under the QPP.

Appendix C

QPP Timeline: Performance Periods, Feedback, Scoring, and Payment Adjustment

The QPP will operate on an overlapping 3-year program cycle. The figure below shows the first three program cycles, which will begin in 2017, 2018, and 2019, respectively. Subject to future rulemaking, program cycle four will begin in 2020, program cycle five in 2021, and so on.



Appendix D

AVAILABLE FORMATS FOR SUBMISSION OF MIPS DATA

Submission Format	Providers			MIPS Categories			
	Individual Clinicians	Group practice (any size)	Group practices of 25+ clinicians only	Quality	Improvement Activities (IA)	Advancing Care Information (ACI)	Cost
Application Program Interface (API) – Registries, qualified clinical data registries, or electronic health records may integrate directly with CMS via API and pass data in QPP data format	√	√		√	√	√	
Extensible Markup Language (XML) – Registries or qualified clinical data registries may generate an XML file in QPP data format and submit to CMS via manual file upload on QPP website	√	√		√	√	√	
Quality Report Document Architecture (QRDA)-III – Export data from EHR in QRDA-III format, then manually upload on QPP website	√	√		√	√	√	
Attestation – Participants may manually attest Advancing Care Information (ACI) and Improvement Activities (IA) measures using the QPP website	√	√			√	√	
Quality Data Code – Supply Quality Data Code on a Part B claim	√			√			
Claims – CMS will score performance in the cost category based on analysis of claims data	√	√					√
CMS Web Interface – Group practice staff may use CMS Web Interface on the QPP Website to download beneficiary sample data, add quality measures data offline, and then upload to CMS Web Interface. For ACI and IA categories, group practice staff may either upload data exported from an EHR or manually attest using the CMS Web Interface.			√	√	√	√	

Source: OIG analysis of CMS's implementation of the QPP, 2017.

Note: Qualified clinical data registries are distinct from regular data registries because they are not limited to submitting MIPS measures. Qualified clinical data registries are permitted to submit alternative measures that, subject to CMS review and approval, will count towards the MIPS score.

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To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Endnotes

[1] Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA), P.L. No. 114-10 (April 16, 2015).
[2] 81 Fed. Reg. 77008 (Nov. 4, 2016).
[3] Clinicians included in the QPP include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. MACRA, § 101(c)(1)(C)).
[4] OIG, *Early Implementation Review: CMS's Management of the Quality Payment Program,* OEI-12-16-00400. Available from: https://oig.hhs.gov/oei/reports/oei-12-16-00400.pdf.
[5] Omnibus Budget Reconciliation Act of 1989, P.L. No. 101-239, § 6102 codified at Social Security Act (SSA) § 1848. The Medicare physician fee schedule is derived using a resource-based relative value scale, which includes three resource components: (1) total physician work, (2) practice expenses, and (3) malpractice expenses. Each component is measured in terms of relative value units (RVUs). The Medicare physician fee schedule payment rates are based on RVUs, adjusted for geography, and multiplied by a national conversion factor to derive dollar amounts.
[6] Section 1848(a)(1) of SSA established the Medicare physician fee schedule as the basis for Medicare reimbursement for all physician services beginning in January 1992.
[7] SSA § 1848(f).
[8] Annual spending targets were updated each year by applying a growth rate known as the sustainable growth rate (SGR). The SGR formula incorporated four factors: (1) inflation, (2) changes in enrollment in Medicare's fee-for-service program, (3) the estimated 10-year average annual growth rate of real gross domestic product per capita, and (4) the impact of changes in law or regulation.
[9] Congressional Budget Office (CBO), *The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates*, September 2006, p. 5. Accessed at https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/09-07-sgr-brief.pdf on October 13, 2016.
[10] CBO, *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline*, July 2012. Accessed at https://www.cbo.gov/publication/41512?index=12240 on October 14, 2016.
[11] MACRA, § 101(c), SSA § 1848(q)(2)(A).
[12] During the first performance period, CMS will calculate cost measures for each clinician, but these will not be included in the MIPS Final Score that determines payment adjustment.
[13] For 2017, the performance period is defined in regulation as "a minimum of a continuous 90-day period within CY 2017, up to and including the full CY 2017." 45 CFR § 414.1320.
[14] CMS will use a "low-volume threshold determination period" to identify providers that meet the low-volume threshold and are thus excluded from MIPS reporting and payment adjustment. The low-volume determination period includes two 12-month segments; a provider who meets the threshold during either of the segments is excluded from MIPS. The initial segment spans from the last 4 months of a calendar year 2 years prior to the performance period through the first 8 months of the next calendar year. The second segment spans from the last 4 months of a calendar year 1 year prior to the performance period through the first 8 months of the performance period in the next calendar year. 81 Fed. Reg. 77008, 77065 (Nov. 4, 2016).
[15] Providers who are exempt from MIPS and are not Qualifying APM Participants will continue to be paid for Medicare Part B services at the Physician Fee Schedule rates without an additional QPP payment adjustment.
[16] CMS, *Quality Payment Program: Pick Your Pace in MIPS*. Accessed at https://qpp.cms.gov/ on September 14, 2017.
[17] MACRA, § 101(e)(2)).
[18] CMS, *2017 MIPS Quality Performance Category Fact Sheet*. Accessed at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-MIPS-Quality-Performance-Category-Fact-Sheet.pdf on November 14, 2017.

[19] CMS, *Advancing Care Information Performance Category Fact Sheet*. Accessed at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Advancing-Care-Information-Performance-Category-Fact-Sheet.pdf on November 14, 2017.
[20] 81 Fed. Reg. 77008, 77817–77831 (Nov. 4, 2016).
[21] Each Advanced APM program has its own established processes for collecting and reporting quality data. Qualifying APM Participants need only to continue following the regular quality-reporting process established by their particular APM program.
[22] Examples include the QPP-Small, Underserved, and Rural Support; Quality Innovation Network-Quality Improvement Organization; and Transforming Clinical Practice Initiative contract programs.
[23] CMS. *Agile Development for Merit-Based Incentive System (MIPS), Solicitation HHSM-500-2016-RFP-0037, Statement of Objectives*. Accessed at https://www.fbo.gov/index?s=opportunity&mode=form&id=a1784e8e8067c0b6b648074ccb8d8d31&tab=core&_cview=1 on October 12, 2016.
[24] Previous GAO and OIG reports have found problems with inaccurate and outdated PECOS data; CMS is continuing to make improvements to the system. See GAO, *Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures,* GAO-17-42, November 2016; GAO, *Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers,* GAO-15-448, June 2015; and OIG, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results,* OEI-03-13-00050, April 2016.
[25] MACRA, § 101(c)(1)(C)(ii)), SSA § 1848(q)(2)(A), 81 Fed. Reg. 77008 (Nov. 4, 2016).
[26] MACRA § 101(c)(1), SSA § 1848(q)(1)(C)(ii), 81 Fed. Reg. 77008, 77062–77070 (Nov. 4, 2016).
[27] CMS has clarified that the preliminary MIPS score provided at the time of data submission does not represent a guarantee of each clinician's final MIPS score. See CMS, *QPP Submissions API Documentation - Scoring Developer Tools*, available at https://qpp.cms.gov/developers.
[28] For example, CMS has partnered with CAPG (formerly known as the California Association of Physician Groups), a nationwide association that represents medical group practices focused on capitated, coordinated care.
[29] 81 Fed. Reg. 77008, 77358–77362 (Nov. 4, 2016).
[30] 81 Fed. Reg. 77008, 77489–77491 (Nov. 4, 2016).
[31] GAO's framework outlines four phases for managing fraud risk: "(1) Commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management; (2) Plan regular fraud risk assessments and assess risks to determine a fraud risk profile; (3) Design and implement strategy with specific control activities to mitigate assessed fraud risk and collaborate to help ensure effective implementation; and (4) Evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management." GAO, *A Framework for Managing Fraud Risks in Federal Programs*, July 2015. Accessed at https://www.gao.gov/products/GAO-15-593SP on September 14, 2017.
[32] CMS, *Quality Payment Program 2017 MIPS Data Validation*, August 2017. Accessed at https://qpp.cms.gov/about/resource-library on September 18, 2017.
[33] OIG, *Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments that Did Not Comply With Federal Requirements*, June 2017. Accessed at https://oig.hhs.gov/oas/reports/region5/51400047.asp on September 14, 2017.
[34] 81 Fed. Reg. 77008 (Nov. 4, 2016).