CAHPS for MIPS
The 2017 Requirements

The Centers for Medicare and Medicaid Services (CMS) has laid out its plans to implement the sweeping payment reforms called for under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. In addition to repealing the Sustainable Growth Rate formula, the MACRA creates the Quality Payment Program that rewards physicians and clinicians for giving better care, not just more care. The Quality Payment Program changes the way physicians and clinicians are paid to incentivize quality and value of care over quantity of services. Previously the Medicare program gathered performance metrics on physicians and other clinicians through a patchwork of programs, including the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program. The Quality Payment Program streamlines these programs, and offers clinicians two paths for participation:

1. The Merit-based Incentive Payment System (MIPS)

or

2. Advanced Alternative Payment Models (APMs)

Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS, which will include components of the existing PQRS, VM, and EHR Incentive Program. As an alternative, CMS has established incentives for clinicians to participate in advanced APMs. Under this pathway, clinicians who take on significant financial risk through entities such as accountable care organizations or bundled payments programs can bypass MIPS and become eligible to receive consistent 5% annual payment increases based on their performance in these risk-based care models. CMS has set 2017 as the performance period for the first MIPS payment adjustment in 2019. Payment adjustments will be based on performance on measures and activities in the four performance categories listed below.

MIPS Performance Category	Replaces	2019 Percentage of MIPS Score	2020 Percentage of MIPS Score	2021 Percentage of MIPS Score
Quality	PQRS & Quality Component of Value Modifier	60%	50%	30%
Advancing Care Information	EHR Meaningful Use	25%	25%	25%
Clinical Practice Improvement Activities	New	15%	15%	15%
Cost (Resource Use)	Value Modifier	NA	10%	30%

The CAHPS for MIPS Survey is one of the measures clinicians may choose to help satisfy the reporting requirements under the Quality category. The following summarizes what we know so far about the 2017 requirements. Contact any member of your HealthStream team to learn more.

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HealthStream

Who is Required to Participate

CMS is not requiring groups to report the CAHPS for MIPS survey for the 2017 transition year of MIPS. However, the survey is available for all MIPS groups to select under the Quality category. The CAHPS for MIPS survey would count as a patient experience measure, which is a of high priority measure. In addition, a MIPS-eligible clinician may be awarded points under the improvement activities performance category. A group may report any five measures within MIPS plus the CAHPS for MIPS survey to achieve the six measures threshold. Although CMS is not requiring groups to participate in the CAHPS for MIPS survey, they have proposed a scoring incentive for those groups who report the CAHPS survey.

Group Practice Responsibilities

Practices that elect to conduct the survey must register by June 30, 2017, and contract with a CMS-approved survey vendor like HealthStream to administer the survey on their behalf.

The Survey

For the 2017 transition year, the CAHPS for MIPS Survey will mirror the CAHPS for PQRS Survey used in 2016. The survey includes 80 questions and is comprised of 12 summary measures.

1. Getting Timely Care, Appointments, and Information
2. How Well Providers Communicate
3. Patient's Rating of Provider
4. Access to Specialists
5. Health Promotion and Education
6. Shared Decision Making
7. Health Status/Functional Status
8. Courteous and Helpful Office Staff
9. Care Coordination
10. Between Visit Communication
11. Helping You to Take Medication as Directed
12. Stewardship of Patient Resources

In future years of the MIPS program, CMS says that it may explore the possibility of updating the survey. Specifically, CMS says it may not finalize all of 12 of the summary measures.

The Focal Provider

The survey names a specific provider who delivered primary care to help orient the beneficiary to the care he or she received. The named provider can be a physician, specialist, nurse practitioner, physician assistant, or clinical nurse specialist. The provider named in the survey will have provided the plurality of a sampled patient's primary care delivered by the group practice. Plurality of care is based on the number of primary care visits to a provider. Sampled patients will be asked to report on their experiences with services provided by the provider within the six months preceding receipt of the survey.

Generating the Patient Sample

CMS will generate the sample by assigning Medicare beneficiaries to a practice based on the plurality of the primary care claims. CMS will then randomly sample from those beneficiaries to create the sample. Assigned beneficiaries must have a plurality of their primary care claims delivered by the group practice.

Exclusions

CMS will exclude beneficiaries under age 18, beneficiaries known to be institutionalized at the time of the sample draw, and beneficiaries with no eligible focal provider.

Sampling Requirements

In 2017, the sample will be based on Medicare claims data. Therefore, only Medicare beneficiaries can be selected to participate in the survey. In future years of the MIPS program, CMS says it may consider expanding the potential patient experience measures to all payers, so that Medicare and non-Medicare patients can be included in the survey sample.

The survey is conducted annually. One quarter of the sample will represent beneficiaries with high utilization of services. CMS will provide a sample of up to 860 beneficiaries per practice. CMS will notify group practices if they do not have a sufficient number of eligible beneficiaries.

Group Size	Maximum Sample	Minimum Sample
100 or more	860	416
25 – 99	860	255
2 – 24	860	125

Key Milestones

CMS has proposed to administer the survey from November 2017 to February 2018.

Data Collection Methodology

CMS requires that the survey be administered using the mixed-mode data collection methodology, which includes a pre-notification letter, followed by up to two waves of mail and up to six attempts by phone.

Suspension of Other Surveys

CMS encourages practices to not conduct other surveys of Original Medicare beneficiaries four weeks prior, during or four weeks after the CAHPS for MIPS Survey administration period. Other CMS-sponsored surveys, such as HCAHPS, are exempt from this recommendation.

Public Reporting

Scores will be posted on the Physician Compare website. Results are reported as top box (the most favorable response option for the measure) and as a star rating (one to five stars).

HealthStream Reporting & Support

In addition to online access to survey results throughout data collection, HealthStream offers a comprehensive report with comparisons to national benchmarks, percentile ranks and identification of priorities for improvement. Practices have access to our complete library of Best Practices, and a detailed report review with a senior member of their dedicated project team. We also help organizations to improve the patient experience and CAHPS survey results through online and on-site assessments, coaching and educational tools. We focus on strategies that have the greatest potential impact for rapid improvement. Learn about our CG Express and CG-CAHPS surveys at: HealthStream's PX Solutions.

CMS Websites

CMS's Quality Payment Program

CAHPS for PQRS

Final Rule

Physician Compare Website