Supporting Statement – Part A
Merit-Based Incentive Payment System (MIPS)
CMS-10450 OCN 0938-1222

A. Background

The Centers for Medicare & Medicaid Services (CMS) requests a three-year clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to implement the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for the Merit-based Incentive Payment System (MIPS). Specifically, the Center for Medicare & Medicaid Services (CMS) will use the CAHPS for MIPS survey to collect data on fee-for-service Medicare beneficiaries' experiences of care with providers participating in the MIPS for use in quality reporting, the Physician Compare website, and annual statistical reports describing MIPS data for all MIPS eligible clinicians. Given that it in first year of implementation CAHPS for MIPS is replacing and using the same questions as CAHPS for the Physician Quality Reporting System (PQRS), CMS is requesting approval as a continuation of OMB control number 0938-1222 used for CAHPS for Physician Quality Reporting.

The MIPS is a new program that supersedes and combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which eligible clinicians and clinician groups will be measured on four performance categories: quality, resource use, clinical practice improvement activities (CPIA), and advancing care information (related to meaningful use of certified EHR technology). Pursuant to the MACRA, the payment adjustments under these three programs will sunset at the end of 2018 along with their associated reporting requirements and will be replaced by and aligned within the MIPS performance categories.

Under current provisions of the PQRS, the CAHPS for PQRS survey is required for group practices of 100 or more eligible clinicians. Although we are not requiring groups to participate in the CAHPS for MIPS survey, we do still believe patient experience is important and we are therefore proposing a scoring incentive for those groups who report via the CAHPS for MIPS survey. Because we believe patients' experiences as they interact with the health care system are important, our proposed MIPS scoring methodology would give bonus points for reporting CAHPS data (or other patient experience measures).

In the MIPS Notice of Proposed Rule Making (NPRM), we propose to allow registered groups of two or more MIPS eligible clinicians to voluntarily elect to participate in the CAHPS for MIPS survey. Specifically, we propose the following criteria for the submission of data on the CAHPS for MIPS survey by registered groups via a CMS-approved survey vendor: for the applicable 12-month performance period, the group must have the CAHPS for MIPS survey

reported on its behalf by a CMS-approved survey vendor. In addition, the group will need to use another submission mechanism (that is, qualified registry, Qualified Clinical Data Registry, EHR, CMS Web Interface) to complete their quality data submission. The CAHPS for MIPS survey would count as one cross-cutting and/or a patient experience measure, and the group would be required to submit at least five additional measures through one other data submission mechanisms. A group may report any five measures within MIPS plus the CAHPS for MIPS survey to achieve the six measures threshold. The administration of the CAHPS for MIPS survey would contain a six-month look-back period. We propose the data collected on the CAHPS for MIPS survey measures would be transmitted to CMS via a CMS-approved survey vendor.

Further, the CAHPS for MIPS survey will be critical to the Physician Compare Web site, which was launched December 30, 2010 to meet requirements set forth by Section 10331 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). The Affordable Care Act requires CMS to establish a Physician Compare website by January 1, 2011 containing information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. By no later than January 1, 2013 (and for reporting periods beginning no earlier than January 1, 2012), CMS is required to implement a plan to make information on physician performance publicly available through Physician Compare. A key component of the reporting requirements under the Affordable Care Act is public reporting, through Physician Compare, of information on physician performance that includes patient experience measures. The collection and reporting of a CAHPS for PQRS survey was developed to fulfill this requirement, and the CAHPS for MIPS survey will continue to do so.

B. Justification

1. Need and Legal Basis

Authority for collection of this information is provided under sections 1848(q), 1848(k), 1848(m), 1848(o), 1848(p), and 1833(z) of the Social Security Act.

Section 1848(q) of the Act, as added by section 101(c) of the MACRA, requires the establishment of the MIPS beginning with payments for items and services furnished on or after January 1, 2019, under which the Secretary is required to: (1) develop a methodology for assessing the total performance of each MIPS eligible clinician according to performance standards for a performance period; (2) using the methodology, provide a composite performance score (CPS) for each MIPS eligible clinician for each performance period; and (3) use the CPS of the MIPS eligible clinician for a performance period to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) to the MIPS eligible clinician for a performance period. Under section 1848(q)(2)(A) of the Social Security Act, a MIPS eligible clinician's CPS is determined using four performance categories: (1)

quality; (2) resource use; (3) clinical practice improvement activity (CPIA), and (4) the advancing care information.

2. Information Users

We will use the CAHPS for MIPS survey to assess groups containing MIPS eligible clinicians performance in the quality performance category. For groups of clinicians electing to report CAHPS in the quality performance category, CAHPS for MIPS will be included in the calculation of the CPS, and applied to performance-based payment differentials. We also will use this information to provide regular feedback reports to MIPS eligible clinicians and groups. This information is made available to beneficiaries, as well as to the public, on the *Physician Compare* website. The data will be used to produce annual statistical reports that will describe the patient experience measures for all MIPS eligible clinicians who elect to use CAHPS for MIPS as one of their quality measures, and for subgroups of clinicians using CAHPS. The MIPS annual statistical reports will be modeled after two existing annual reports, the PQRS Experience Report and the Value Modifier Report.

This survey also supports the administration of the Quality Improvement Organizations Program (QIO Program). The Social Security Act, as set forth in Part B of Title XI - Section 1862(g), established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organizations Program. The statutory mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. This survey will provide patient experience of care data that is an essential component of assessing the quality of services delivered to Medicare beneficiaries. It also would permit beneficiaries to have this information to help them choose health care providers that provide services that meet their needs and preferences, thus encouraging providers to improve quality of care that Medicare beneficiaries receive.

3. Use of Information Technology

CMS-approved survey vendors are required to collect the data via a mixed mode data collection strategy that involves two rounds of mailed surveys followed by phone interviews. The mailed survey formatted for data scanning and data from all returned surveys will be scanned into an electronic data file. Computer Assisted Telephone Interview (CATI) will be used as the secondary mode of data collection if a beneficiary does not respond to two mailed requests to complete the survey.

4. Duplication of Efforts

The CAHPS for MIPS survey (formerly known as the CAHPS for PQRS survey) consists

of the core CAHPS Clinician & Group Survey developed by AHRQ, plus additional survey questions to meet CMS's information and program needs. The survey was designed to gather only the necessary data that CMS needs for assessing physician quality performance, and related public reporting on physician performance, and should complement other data collection efforts.

The administration of CAHPS for MIPS will not overlap with the administration of its predecessor, CAHPS for PQRS. The final CAHPS for PQRS survey will be administered from November 2016 through February 2017 for data related to the final PQRS performance period in 2016. The administration period for the first CAHPS for MIPS survey is planned for November 2017 through February 2018 with regard to the first MIPS performance period in 2017.

5. Small Businesses

Survey respondents are Fee-for-Service Medicare Beneficiaries who have received care from groups participating in MIPS during the performance period prior to the survey. The survey's reporting burden should not impact small businesses or other small entities.

6. Less Frequent Collection

If patient experience data are not collected annually as measures to support the quality performance category, we will not be able to fully implement the MACRA requirement to: (1) emphasize patient experience measures among the quality measures a MIPS eligible clinician or group may use to meet the performance criteria for a payment adjustment under MIPS, (2) calculate for payment adjustments to MIPS eligible clinicians or groups, and (3) publicly post provider performance information on the *Physician Compare* website.

A further consequence of collecting data on a less frequent basis than annually is that the beneficiaries will be less able to recall their specific experiences with care over longer periods of time. If the survey asks about patient experiences over longer periods, responses may be less reliable.

Additionally, if data was collected on less than an annual basis the patient experience scores information reported on Physician Compare would be less current and as a result less useful to beneficiaries and consumer intermediaries who may visit the website.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after

receipt of it;

- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The proposed rule serves as the 60-day Federal Register notice which published on May 9, 2016 (81 FR 28162). The proposed rule was placed on public inspection on April 27, 2016 and ICR related comments are due July 8, 2016.

9. Payments/Gifts to Respondents

There will be no payments/gifts to respondents.

10. Confidentiality

Consistent with federal government and CMS policies, individuals contacted as part of this data collection will be assured of the confidentiality of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C. 552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974), and OMB Circular A-130.

11. Sensitive Questions

The survey does not include any questions of a sensitive nature.

12. Burden Estimates (Hours & Wages)

Beneficiaries will experience burden under the CAHPS for MIPS survey. The usual practice in estimating the burden on public respondents to surveys such as the CAHPS for MIPS survey is

to assume that respondent time is valued, on average, at civilian wage rates. In order to calculate the costs to beneficiaries for their time, we have used U.S. Bureau of Labor Statistics (BLS) estimates for employer costs for employee compensation for civilian, all occupations. We have not adjusted these costs for fringe benefits and overhead because only the direct wage costs represent the "opportunity cost" to beneficiaries themselves for time spent in health care settings. The BLS data show the average hourly wage for civilians in all occupations to be $23.06. Although most Medicare beneficiaries are retired, we believe that their time value is unlikely to depart significantly from prior earnings expense, and have used the average hourly wage to compute the dollar cost estimate for these burden hours.

TABLE 1: Hourly Wages Used in Burden Estimate

Occupation Title	Occupational Code	Mean Hourly Wage ($/hr.)	Fringe Benefits and Overhead ($/hr.)	Adjusted Hourly Wage ($/hr.)
Civilian, All Occupations	Not applicable	23.06[i]	N/A	23.06

[i] Source: "December 2015 Employer Costs for Employee Compensation". U.S. Department of Labor, Bureau of Labor Statistics, http://www.bls.gov/news.release/archives/ecec_03102016.htm.

Under the first performance period of MIPS, we assume that 434 groups will elect to report on the CAHPS for MIPS survey, which is equal the number of groups reporting via CAHPS for the PQRS in 2014. Table 2 shows the estimated annualized burden for beneficiaries to participate in the CAHPS for MIPS survey. Based on historical information on the numbers of CAHPS for PQRS survey respondents, we assume that an average of 287 beneficiaries will respond per group. The CAHPS for MIPS survey will be administered to approximately 121,688 beneficiaries per year (434 groups X an average of 287 beneficiaries per group responding). The survey contains 81 items and is estimated to require an average administration time of 18.0 minutes in English (at a pace of 4.5 items per minute) and 21.6 minutes in Spanish (assuming 20 percent more words in the Spanish translation), for an average response time of 19.8 minutes or 0.33 hours. These burden and pace estimates are based on CMS's experience with surveys of similar length that were fielded with Medicare beneficiaries. As indicated below, the annual total burden hours are estimated to be 40,157 hours (121,688 respondents X .33 burden hours per respondent to report). The estimated total burden annual burden cost is $926,021 (40,157 total burden hours X $23.06 per hour)

TABLE 2: Burden Estimate for Beneficiary Participation in CAHPS for MIPS Survey

	Burden Estimate
Estimated # of Groups Administering CAHPS for MIPS survey (a)	434
Estimated # of Beneficiaries Per Group Responding to Survey (b)	287
Estimated # of Total Respondents Reporting (c)=(a)*(b)	121,688
Estimated # of Burden Hours Per Respondent to Report (d)	0.33
Estimated Cost Per Beneficiary Reporting (at cost rate of $23.06) (e)	$7.77

Estimated Total Annual Burden Hours (f) = (c)*(d)	**40,157**
Estimated Total Annual Burden Cost for Beneficiaries Responding to CAHPS for MIPS (g)=(a)*(e)	**$926,021**

13. Capital Costs

Survey participants will incur not capital costs as a result of participation.

14. Cost to Federal Government

The total annual cost to the Federal government for CAHPS for MIPS Survey is estimated to be $2,120,324. This total includes CMS selecting samples of Medicare beneficiaries aligned with the groups electing to use CAHPS, and providing the list of sampled beneficiaries to CMS-approved survey vendors. The total annual cost also includes the annual approval process for survey vendors; training, oversight, and technical assistance of the approved survey vendors; preparation and cleaning of data submitted by the survey vendors; data analysis; preparation of CAHPS measures for public reporting on Physician Compare, and in the feedback reports for clinician groups reporting on CAHPS measures.

15. Program or Burden Changes

The changes in the estimated annual burden for CAHPS for MIPS is 627 hours higher than the previously approved the burden estimate for the CAHPS for PQRS burden. The change in the burden is the result of an increase in the number of groups reporting CAHPS patient experience measures over time.

The previously approved CAHPS for PQRS information collection, assumed 425 groups per year. Hence, the estimated total number of beneficiaries surveyed was 117,300 (425 groups x 287 beneficiaries per group) with total burden hours of 39,530 per year (117,300 X 0.337), and annual burden cost of $911,562 (39,530 x $23.06)

As noted above, we estimate that 121,688 beneficiaries would complete CAHPS for MIPS surveys each year, with total burden hours of 40,157 hours per year and an annual burden cost of $926,021. As noted above, we estimated that 434 groups will elect to use CAHPS for MIPS as one of their six quality performance category measures each year, based on historical PQRS data on groups electing to use CAHPS for PQRS.

Hence, as compared to CAHPS for PQRS, the annual burden estimate under CAHPS for MIPS includes an additional 4,388 beneficiaries, an additional 627 annual burden hours, and a change in annual burden cost of $14,459.

16. Publication and Tabulation Dates

To ensure that MIPS results are useful and accurate, CMS plans to provide performance feedback to MIPS eligible clinicians, including feedback on patient experience measures. Beginning July 1, 2017, we propose to include information on the quality and resource use performance categories in the performance feedback. Initially, we propose to provide performance feedback on an annual basis. In future years, we may consider providing performance feedback on a more frequent basis as well as adding feedback on the CPIA and advancing care information performance categories. In the NPRM we propose to make performance feedback available using a CMS designated system.

CMS plans to publicly report patient experience measures through the *Physician Compare* website. The public reporting is anticipated to start in late 2018 for the 2017 performance period. We also plan to include CAHPS for MIPS data in annual statistical reports that will describe the reporting experience of MIPS eligible clinicians as a whole and subgroups of MIPS eligible clinicians.[1]

17. Expiration Date

We are requesting approval for this information collection for a period of three years. The expiration date will be displayed on the CAHPS for MIPS Survey Instruments and beneficiary letters.

18. Certification Statement

There are no exceptions to the certification statement.

[1] The MIPS annual statistical reports will be modeled after two existing annual reports, the PQRS Experience Report and the Value Modifier Report.