Approach Towards Next Generation Clinical Quality Improvement: Success through New Standards, Programs, and Activities

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Disclaimer

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The opinions or suggestions here are mine and have not been endorsed by HHS leadership.
I have no conflicts of interest to report.
Achieving Real Innovation in Clinical Quality Improvement Through (or Despite) New Federal Programs

- New programs allow more flexibility regarding who qualifies for (has to participate) in pay-for-performance...
- New programs allow more optionality in how to choose measures and report data...
- Payments will be adjusted due to federal regulations...
- New requirements may or may not add value to your current practice paradigm...
- You are in control of whether you succeed and your care improves (note: these are not mutually exclusive but not necessarily related)
What is a “Final Rule with Comment”? 

- MACRA/MIPS was published on October 14, 2016 as a “Final Rule with Comment”
- This means that it is still a Final Rule!
  - CMS will not be republishing any other versions of the rule for performance period 2017*
- This means you can and should provide public comment!
  - CMS does want and need your feedback on the rule in regards to subregulatory guidance, post-regulatory contingencies, and future (2018) changes
Why MACRA?
Medicare Access and CHIP Reauthorization Act of 2015

Beginning in 2019, all current Medicare payment, including incentive programs, will be combined into one Merit-Based Incentive Payment System (MIPS), replacing all Medicare reimbursement for eligible professionals.

The MIPS program will use four performance measures to determine reimbursement, which will begin in 2019:

- Quality;
- Resource use;
- Clinical practice improvement activities; and
- Meaningful use of certified EHR technology (Advancing Care Information)

Privacy and security including HIPAA are also requirements and failure to adhere to required standards results in penalties.
CMS Quality and Performance Programs (2014)

**Hospital Quality**
- Medicare and Medicaid EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- HAC reduction program
- Readmission reduction program
- Outpatient Quality Reporting
- Ambulatory Surgical Centers

**Physician Quality Reporting**
- Medicare and Medicaid EHR Incentive Program
- PQRS
- eRx quality reporting

**PAC and Other Setting Quality Reporting**
- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTCH Quality Reporting
- Hospice Quality Reporting
- Home Health Quality Reporting

**Payment Model Reporting**
- Medicare Shared Savings Program
- Hospital Value-based Purchasing
- Physician Feedback/Value-based Modifier*
- ESRD QIP

**“Population” Quality Reporting**
- Medicaid Adult Quality Reporting*
- CHIPRA Quality Reporting*
- Health Insurance Exchange Quality Reporting*
- Medicare Part C*
- Medicare Part D*

*Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.
Mandated coordination across agencies and programs:

HHS Measurement Alignment

MU, PQRS, IQR, ACO, VBP, HRSA, CDC

Unified Outcome Measures

EHR as primary reporting platform, with secondary reporting from registry, claims
MIPS/QPP Builds on Existing CMS Programs

- Many providers have noted that the expansion of quality programs has distracted from, rather than added to the focus on providing quality care.
- Need for alignment with non-federal programs has been recognized but not addressed.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS.</td>
<td>New category.</td>
<td>Replaces the Medicare EHR Incentive Program also known as Meaningful Use.</td>
<td>Replaces the Value-Based Modifier.</td>
</tr>
</tbody>
</table>
Medicare Shared Savings Program

- Section 3022 of the Affordable Care Act which states that Medicare-enrolled providers and suppliers ACOs that meet quality and cost goals share in savings generated.

- Voluntary national program—3 year agreement, choice of track

- Required to develop processes to promote evidence-based medicine, patient engagement, care coordination, and internally report on cost and quality.
  - 180,000 participating physicians and other practitioners.
  - ACOs serve over 7.7 million assigned Medicare fee-for-service beneficiaries.
    - ACO quality reporting satisfies PQRS and VM reporting requirements for eligible practitioners participating in the ACO.

- Most recent results (performance year 2015) show continued quality improvement and more ACOs share savings over time.
  - In 2015, Medicare Shared Savings Program ACOs had a combined total program savings of $429 million.
  - ACOs that reported quality in both 2014 and 2015 improved on 84 percent of the quality measures that were in the measure set in both years. Average quality performance improved by over 15 percent on several measures, including blood pressure screening and follow up.
Clinicians who receive a substantial portion of their revenues (at least 25% of Medicare revenue in 2018-2019 but threshold will increase over time) from qualifying alternative payment mechanisms will not be subject to MIPS.

While the definition of a qualifying APM has yet to be determined, MACRA outlines criteria which includes but is not limited to:

- **Quality Measures**
- **Advancing Care Information**
- **Risk-sharing**

Adjustments based on the **composite performance score** of each eligible physician or other health professional on a 0-100 point scale based on the following performance measures. All scores noted below are for the first MIPS year and are subject to adjustment. Additional positive adjustment available for exceptional performance.

- **Quality** (60% of MIPS score 1st year)
- **Clinical Practice Improvement Activities** (15%)
- **Resource Use** (0% 1st year)
- **Advancing Care Information** (25%)
What models are Advanced APMs?

In 2017, we anticipate that these will be Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3

This list may change. We’ll publish a final list before January 1, 2017.

How do I join an Advanced APM?

• Learn about [specific Advanced APMs](#) and how to apply.

If you’re in an Advanced APM, you’ll earn the 5% incentive payment in 2019 if:

• You receive 25% of your Medicare Part B payments through an Advanced APM or
• See 20% of your Medicare patients through an Advanced APM

Participate in the Advanced APM path:

If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.
2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
QPP Penalties

Failing to perform to the program can result in payment penalties or incentives:

Eligible professionals with higher performance scores receive an incentive up to three times the annual cap for negative payment adjustments.

Nationwide interoperability is a requirement by December 31, 2018*
A Thought Experiment: How a Clinician/Fed Would Leverage MIPS to Become a Leader in Quality, Safety and Care Process Innovation

- As a clinician, I want participating in quality measurement and practice improvement to be meaningful to my practice
- As a patient, I want quality measures to accurately reflect care priorities and practice activities
- As a federal employee, I want this program to allow the US to achieve big gains in quality of care and to bend the cost curve
- As an informaticist, I want these programs to lead to innovation and greater exchange of information and content
Taking the Easy Path or “How to Win for the Sake of Winning”

• MIPS is a program designed to bring in new providers, specialties, and settings/sites
• Therefore it represents the “floor” of what’s needed (or some have argued, the “basement”)
• It is relatively easy to do the minimum work to avoid payment adjustments or even get incentives
• HOWEVER...This approach does NOT help your patients, providers or your future
How to Position Yourself on the Leading Edge

• Instead of aiming for the basement, take this opportunity to aim for the sky!
• Since just reporting for 2017 allows you to avoid negative payments, this is the time for you to be aggressive, take chances, and become innovators
• The community can in this crucial time push CMS to encourage innovation in future years of the program
• Watch CMS and others for cues to the “future” of real pay-for-quality and integrated care and you will be well prepared for success
How to Position Yourself on the Leading Edge

1. Look towards new standards

2. Consider creating or using measures that are more meaningful:
   1. Outcomes and risk adjustment
   2. Special populations, specialty measures
   3. Multidimensional interventions

3. Consider new practice and care processes
   1. Care plans and coordination
   2. Sophisticated risk assessment and targeted interventions
New Standards for Use in MIPS

• As part of CMS’ flexibility, they are less prescriptive about how measure data are generated

• Thus, you can theoretically use ANY standard provided you can generate reports in the accepted formats that CMS will accept

  » This includes FHIR technically

• CMS has not yet released formal guidance on their reporting requirements
The Current State vs the HHS Future Vision for Clinical Quality Improvement

**Current State**
- CQMs and CDS are separate
- Each vendor develops their own CDS artifacts
- CQMs are focused on retrospective data
- CDS is an afterthought

**Future Vision**
- CDS drives care activities
- Performance is consistently improved through CDS
- CQM data capture is automatic
- CQMs are available with paired optional CDS artifacts

Clinical Decision Support can be used to capture clinical quality data, drive performance improvement activities, and improve performance scores
Standards improvement and harmonization:
Clinical Quality Measurement and Clinical Decision Support

- CQM Specific Standards
  - HQMF
  - QRDA Category-1
  - QRDA Category-3
  - QDM

- Common Metadata Standard
- Common Data Model Standard (QI Core/FHIR)*
- Common Expression Logic Standard (CQL)**

- CDS Specific Standards
  - HeD
  - vMR

* Quality Improvement and Clinical Knowledge
** Clinical Quality Language
Future Standards Need to be Interoperable to Each Other to Allow Flexibility

Authors use CQL to produce libraries containing human-readable yet precise logic.

ELM XML documents contain machine-friendly rendering of the CQL logic. This is the intended mechanism for distribution of libraries.

Implementation environments will either directly execute the ELM, or perform translation from ELM to their target environment language.
Proposed 2018 Standards Evolution for CMS eCQM Specifications

Diagram showing the evolution of standards from HQMF (Metadata, Population Structure) and QDM (Logic) and QDM (Data Model) to HQMF (Metadata, Population Structure), CQL (Logic), and QDM (Data Model).
Advanced Next Generation Standards for Clinical Quality Improvement
Next Generation Standards for Clinical Quality: FHIR
https://hl7-fhir.github.io/clinicalreasoning-module.html
HSPC: Healthcare Services Platform Consortium
“The iPhone Approach”

SMART on FHIR®© – Open Platform Architecture

- SOA Orchestration
- mHealth
- OAuth
- FHIR®© REST API
- Clinical Element Models & FHIR Data Profiles
- Exhibiting Health IT Systems

http://smartplatforms.org/smart-on-fhir/
CMS Reporting Requirements for MIPS

• CMS reporting requirements are not formally outlined in the MIPS final rule— they will therefore be defined in subregulatory guidance

• Stakeholders may want to provide guidance on the following standards-based reporting methods:
  » CMS has been considering removing QRDA reporting from MIPS in the near future
  » CMS is planning to launch an API to an undetermined standard for 2017 reporting
How to Position Yourself on the Leading Edge

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2. Consider creating or using measures that are more meaningful:
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## Quality Measurement

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<th>Quality</th>
<th>Replaces the Physician Quality Reporting System (PQRS).</th>
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</table>

**Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.

**Groups using the web interface:** Report 15 quality measures for a full year.

**Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality.
Moving Towards New and More Meaningful Measures

- MIPS allows reporting of specialty and new meaningful measures using registries
- MIPS requires the use of one outcome measure but expresses a future direction towards outcome-based performance
- Initial MIPS restricts reporting across groups but original MACRA legislation and comments have described virtual groups which could be subset from larger groups or created from groups of individuals
- Note reporting using multiple reporting formats is allowed
Moving Towards New and More Meaningful Measures

• Specialty societies and others can sponsor and propose measures for inclusion in MIPS/registries

• Measures could be built on reliable common data elements as applications that can be plug and play

• Measures that mine data from applications and multiple sources reduce the burden on providers to enter data

  » For example, a depression screening or functional status measure could use PHR or app data to gather data directly from the patient
Moving Towards New and More Meaningful Measures

- Existing measures from MU can often continue to be captured to generate additional measure options
- In 2017 it makes sense to focus on gathering meaningful and outcome-focused measures to prepare for future years of MIPS
- Focusing on adding new data elements and reviewing/validating performance data should be a major focus to ensure accurate performance and adding new opportunities for measurement
1. Look towards new standards

2. Consider creating or using measures that are more meaningful:
   1. Outcomes and risk adjustment
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Comprehensive Primary Care (+/- Plus)

**Track 1**

Up to **2,500** primary care practices.

Pathway for practices ready to build the capabilities to deliver comprehensive primary care.

**Track 2**

Up to **2,500** primary care practices.

Pathway for practices poised to increase the **comprehensiveness** of care through enhanced health IT, improve care of patients with **complex needs**, and inventory resources and supports to meet patients’ **psychosocial needs**.
Comprehensive Primary Care (+/- Plus)

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$15 average</td>
<td>$2.50 opportunity</td>
<td>Standard FFS</td>
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<table>
<thead>
<tr>
<th>Track 2</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$28 average; including $100 to support patients with complex needs</td>
<td>$4.00 opportunity</td>
<td>Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>
Comprehensive Primary Care (+/- Plus)

Access and Continuity
- 24/7 patient access
- Assigned care teams
- Risk stratify patient population
- Short and long-term care management
- Identify high volume/cost specialists serving population
- Follow-up on patient hospitalizations

Care Management
- E-visits
- Expanded office hours
- Care plans for high-risk chronic disease patients
- Behavioral health integration
- Psychosocial needs assessment and inventory resources and supports

Comprehensiveness and Coordination
Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.

Groups with fewer than 15 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

Participants in certain APMs under the APM scoring standard, such as Shared Savings Program Track 1 or the Oncology Care Model: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.
Clinical Performance Improvement Activities

A selection of CPIA activities that link to advanced care activities and quality improvement/measurement:

- Anticoagulant Management Improvement
- Care Transition Operational Improvement
- Chronic Care and Preventative Care Management
- Depression Screening
- Diabetes Screening
- Electronic Health Record Enhancements for Behavioral Health
- Engagement of Patients, Family and Caregivers in Developing a Plan of Care
- Engage Patients and Families to Guide Improvement in the System of Care
Clinical Performance Improvement Activities

A selection of CPIA activities that link to advanced care activities and quality improvement/measurement (cont):

• Evidence-based Techniques to Promote Self-management into Usual Care
• Glycemic Management Services
• Condition-specific Chronic Disease Self-management Support
• Implementation of Practices/processes that Document Care Coordination
• Implementation of Fall Screening and Assessment Programs
• Implementation of Formal Quality Improvement Methods, Practice Changes, or Other Practice Improvement Processes
• Implementation of Medication Management Practice Improvements
• And Many More...
Parting Words of Wisdom (or Hindsight)

• Create a comprehensive plan with a “floor” and a “ceiling”
• Connect Quality activities with clinical decision support and Practice Improvement to consolidate resources and impart meaning to quality
• Move towards advanced care processes in support of the same above and patient-centered engagement
• No plan will succeed without testing and validation
• Look to leverage external content and select domains based on your providers, setting and patient population
Current final rule leaves a lot of uncertainty regarding technical requirements

CMS would benefit greatly from actionable and specific feedback in the immediate comment period to impact both the 2017 implementation and requirements as well as future years

Taking the easy path now may put you at risk later

Create a coherent plan from the outset and align multiple criteria to avoid duplication of effort
• New programs allow more flexibility regarding who qualifies for (has to participate) in pay-for-performance...
• New programs allow more optionality in how to choose measures and report data...
• Payments *will be adjusted* due to federal regulations...
• New requirements may or may not add value to your current practice paradigm...
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Thank you and Questions

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