MACRA & the Quality Payment Program

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Wyoming Quality Health Care Conference

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What You Will Learn Today

- WHY Payment Reform – what brought us here?
- WHAT is MACRA and the Quality Payment Program (QPP)?
- HOW do we plan for MIPS?
- WHERE does this lead in the future?
Why is Payment Reform Needed?
From a High Level


**Quality** – of 11 industrialized nations in the Commonwealth Study, the U.S. ranked last. ([http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror](http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror))
Cost - Global Comparison (2013 Data)

Source: OECD Health Statistics 2015

1 Preliminary estimate.
2 Data refer to 2012.
The Trend Line

Health Care Spending as a Percentage of GDP, 1980-2015

Source: OECD Health Data 2015. Note: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only and exclude spending on capital formation of health care providers.
On a per capita basis, health spending has grown substantially.

Total national health expenditures, US $ per capita, 1970-2013

Source: National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group Peterson-Kaiser Health System Tracker
Wages, Inflation and Insurance

Premiums

The Quality Story
# Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>Top 2*</th>
<th>Middle</th>
<th>Bottom 2*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Ranking (2013)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality Care</strong></td>
<td>2</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Effective Care</td>
<td>4</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Safe Care</td>
<td>3</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>5</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>8</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>9</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>4</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>5</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td><strong>Healthy Lives</strong></td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>Health Expenditures/Capita, 2011</strong></td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
</tr>
</tbody>
</table>

Notes: * Includes ties. ** Expenditures shown in US PPP (purchasing power parity); Australian $ data are from 2010.
Where Does the Money Go?

Top 1% of spenders account for >20% of spending ($275 billion)

Top 5% of spenders account for almost half of spending ($523 billion)

NIHCM Foundation analysis of data from the 2009 Medical Expenditure Panel Survey.
Payment Reform
The vision and the methods
Payment Reform – the Vision

For every $1:

- We buy:
  - $0.40 Waste
  - Preventable Complications
    - Unnecessary Treatments
    - Inefficiencies
    - Errors
  - High Quality, Necessary Services

- We should buy:
  - $0.60 Quality
  - Cost Savings
  - High Quality, Necessary Services
  - 100% Quality for Less Cost
Public and Private Payment Reforms

• Federal programs
  - MACRA and the QPP
  - Bundled payments
  - Payment models
    ▪ Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs), Shared-risk programs

• State initiatives
  - Medicaid managed care
  - Other patient-centered, primary care models

• Private models
  - ACOs
  - Patient-centered or primary care medical homes
Enter MACRA

- Where CMS goes, others will follow
- Track/report quality of care
- Understand and act on information about the cost of care
- Use technology to support internal improvement efforts as well as coordinate across the continuum of care
- Will very likely lead to changes in patient engagement and experience
Pay for What Works

• Reward high quality, efficient and effective care
• Increasing focus on quality measures that measure outcomes not just activities
  - Process measures
    ▪ Eye exam
    ▪ Foot exam
  - Outcomes measures
    ▪ HgbA1C
    ▪ Blood pressure under control
The intent of MACRA is four-fold:

1. Sustainable Growth Rate (SGR) repeal
2. Improve care for Medicare beneficiaries
3. Reauthorizes the Children’s Insurance Program (CHIP)
4. Change our physician payment system from focus on quantity of services to quality of care
MACRA = Quality Payment Program

- MACRA is being implemented as the Quality Payment Program (QPP)
- The QPP encompasses two pathways:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
Merit-based Incentive Payment System (MIPS)
Merit-Based Incentive Payment System (MIPS)

MIPS streamlines the existing programs into one program:

- Physician Quality Reporting System (PQRS) → Quality
- Value-Based Modifier → Cost
- Meaningful Use of EHRs → Advancing Care Information

MIPS also adds a new category:

- Improvement Activities (IA)
### MIPS Breakdown

A physician’s MIPS composite score, which determines future payment adjustments, is calculated through a changing ratio of four key categories of information each year.

<table>
<thead>
<tr>
<th>Category</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Decreases</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost Increases</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
An Action Plan for MIPS
Nine Steps to Reporting in MIPS

1. Am I Included in MIPS?
You are required to report MIPS in the Quality Payment Program for performance year 2017 unless you fall below the low volume threshold or are a Qualifying Participant in an Advanced Alternative Payment Model (APM). Check to see if you need to participate using your NPI number: https://qpp.cms.gov/realistic

2. Decide if clinicians in your practice will participate as a group or individually.
An individual is a single NPI tied to a single tax ID number. Medicare payment adjustment is based on individual performance.

Nine-Step Guide to Reporting in the Merit-based Incentive Payment System (MIPS)
MIPS Eligible Clinicians

Medicare Part B clinicians billing more than $30,000 a year AND providing care for more than 100 Medicare patients a year.

Quick Tip: 
**Physician** means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state in which he/she performs this function.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
Who is Excluded from MIPS?

**Newly-enrolled in Medicare**
- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

**Below the low-volume threshold**
- Medicare Part B allowed charges less than or equal to $30,000 a year
  - OR
- See 100 or fewer Medicare Part B patients a year

**Significantly participating in Advanced APMs**
- Receive 25% of your Medicare payments
  - OR
- See 20% of your Medicare patients through an Advanced APM
STEP 1 - CHECK MIPS ELIGIBILITY
MIPS Eligibility Letters

- Letters mailed from Centers for Medicare & Medicaid Services (CMS) late April – May 2017
- Assist in determining eligibility/requirement for MIPS reporting
- Groups by TIN and individuals by NPI
- Letter plus attachments A & B
For MIPS Eligibility Lookup visit QPP.CMS.gov
STEP 2 – DECIDE TO PARTICIPATE AS A GROUP OR AS AN INDIVIDUAL
Group or Individual?

- **Individual** – a single NPI tied to a single tax ID number (TIN). Payment adjustment is based on individual performance.

- **Group** – a set of two or more eligible clinicians sharing a common tax ID number (TIN) whose Medicare payment is based on the group’s performance.
Factors to Consider

- Cost
- Financial Impact
- Vendor capabilities
- Administrative effort
- Public reporting on Physician Compare
- Culture
  - Individual Accountability
  - Common group of patients
STEP 3 – CONSIDER ELECTRONIC HEALTH RECORD (EHR) STATUS
EHR Technology

• Patient engagement, quality improvement and population health management efforts enhanced through technology

• Consider selecting or upgrading to certified EHR technology

• For a full list of certified EHR technology see: https://chpl.healthit.gov/
STEP 4 – CONSIDER YOUR REPORTING PERIOD
Pick Your Pace in 2017 (Transition Year)

### Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

### MIPS

- **Test Pace**
  - Submit something
- **Partial Year**
  - Report for 90-day period after January 1, 2017
  - Neutral or small payment adjustment
- **Full Year**
  - Fully participate starting January 1, 2017
  - Modest positive payment adjustment

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**Not participating in the Quality Payment Program for the transition year will result in a negative 4 percent payment adjustment.**
STEP 5 – SELECT HOW YOU WILL REPORT MIPS DATA
# Submission Methods for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>- Qualified Clinical Data Registry (QCDR)</td>
<td>- QCDR</td>
</tr>
<tr>
<td></td>
<td>- Qualified Registry</td>
<td>- Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>- EHR</td>
<td>- EHR</td>
</tr>
<tr>
<td></td>
<td>- Claims</td>
<td>- Administrative Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- CAHPS for MIPS Survey</td>
</tr>
<tr>
<td><strong>Improvement Activities</strong></td>
<td>- QCDR</td>
<td>- QCDR</td>
</tr>
<tr>
<td></td>
<td>- Qualified Registry</td>
<td>- Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>- EHR</td>
<td>- EHR</td>
</tr>
<tr>
<td></td>
<td>- Attestation</td>
<td>- CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Attestation</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td>- QCDR</td>
<td>- QCDR</td>
</tr>
<tr>
<td></td>
<td>- Qualified Registry</td>
<td>- Qualified Registry</td>
</tr>
<tr>
<td></td>
<td>- EHR</td>
<td>- EHR</td>
</tr>
<tr>
<td></td>
<td>- Attestation</td>
<td>- CMS Web Interface</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Attestation</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>- No submission required</td>
<td>- No submission required</td>
</tr>
<tr>
<td></td>
<td>- <em>CMS will use claims data</em></td>
<td>- <em>CMS will use claims data</em></td>
</tr>
</tbody>
</table>

*Note: All methods outlined are used for MIPS except where noted.*
For the 207 Performance Year

- Only one data submission mechanism PER CATEGORY is allowed in year one.

- In the 2018 *proposed rule*, CMS is considering allowing submission from multiple options for each category.
STEP 6 – CHOOSE YOUR MEASURES
MIPS Category: Quality

270+ Measures Available

• **Most participants** report up to six 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.

• Strongly consider reporting additional high priority and outcome quality measures to maximize potential bonus points.

For a full list of measures, please visit [QPP.CMS.gov/measures/quality](http://QPP.CMS.gov/measures/quality)
### Select Quality Measures

**Select Measures**

- **High Priority Measures**
- **Specialty Set**

#### By searching: Keywords

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Add</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use</td>
<td>![Add Button]</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
<td>![Add Button]</td>
</tr>
<tr>
<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
<td>![Add Button]</td>
</tr>
<tr>
<td>Adherence to Antipsychotic Medications For Individuals with Schizophrenia</td>
<td>![Add Button]</td>
</tr>
</tbody>
</table>

#### Data Submission Method

- **Selected Measures**
  - 0 Measures Added

*Disclaimer*

*MIPS eligible clinicians or groups are expected to report on applicable measures. “Applicable” is defined as measures relevant to a particular MIPS participating clinician’s population of patients.*
# Quality - Benchmarks

<table>
<thead>
<tr>
<th>Measure_Name</th>
<th>Measure_ID</th>
<th>Submission_Method</th>
<th>Decile 3</th>
<th>Decile 4</th>
<th>Decile 5</th>
<th>Decile 6</th>
<th>Decile 7</th>
<th>Decile 8</th>
<th>Decile 9</th>
<th>Decile 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Influenza</td>
<td>110</td>
<td>Claims</td>
<td>22.64 - 31.75</td>
<td>31.76 - 43.13</td>
<td>54.87 - 66.39</td>
<td>66.39 - 77.47</td>
<td>77.47 - 92.03</td>
<td>92.03 - 99.99</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza</td>
<td>110</td>
<td>EHR</td>
<td>11.22 - 18.57</td>
<td>18.58 - 24.99</td>
<td>25.00 - 31.84</td>
<td>31.85 - 38.92</td>
<td>38.93 - 47.85</td>
<td>47.85 - 59.99</td>
<td>80.00 - 79.01</td>
<td>&gt;=79.02</td>
</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>111</td>
<td>Claims</td>
<td>39.78 - 51.32</td>
<td>51.33 - 61.67</td>
<td>61.68 - 70.47</td>
<td>70.47 - 77.77</td>
<td>77.77 - 84.49</td>
<td>84.50 - 91.99</td>
<td>92.00 - 95.06</td>
<td>&gt;=95.07</td>
</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>111</td>
<td>EHR</td>
<td>14.13 - 23.25</td>
<td>23.26 - 33.02</td>
<td>33.03 - 43.58</td>
<td>43.59 - 53.96</td>
<td>53.97 - 63.60</td>
<td>63.61 - 74.54</td>
<td>74.54 - 85.52</td>
<td>&gt;=85.53</td>
</tr>
<tr>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>111</td>
<td>Registry/QCDR</td>
<td>12.24 - 24.02</td>
<td>24.03 - 36.34</td>
<td>36.35 - 48.51</td>
<td>48.52 - 58.95</td>
<td>58.95 - 68.05</td>
<td>68.06 - 77.77</td>
<td>77.77 - 90.19</td>
<td>&gt;=90.20</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>112</td>
<td>Claims</td>
<td>38.46 - 48.01</td>
<td>48.02 - 55.67</td>
<td>55.68 - 62.78</td>
<td>62.78 - 69.41</td>
<td>69.42 - 77.18</td>
<td>77.19 - 87.87</td>
<td>87.87 - 98.52</td>
<td>&gt;=98.53</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>112</td>
<td>EHR</td>
<td>12.41 - 22.21</td>
<td>22.22 - 32.30</td>
<td>32.31 - 40.86</td>
<td>40.87 - 47.91</td>
<td>47.92 - 55.25</td>
<td>55.26 - 63.06</td>
<td>63.07 - 73.22</td>
<td>&gt;=73.23</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>112</td>
<td>Registry/QCDR</td>
<td>14.49 - 24.52</td>
<td>24.53 - 35.70</td>
<td>35.71 - 46.01</td>
<td>46.02 - 55.06</td>
<td>55.07 - 63.67</td>
<td>63.68 - 74.06</td>
<td>74.07 - 87.92</td>
<td>&gt;=87.93</td>
</tr>
</tbody>
</table>
MIPS Category: Advancing Care Information (ACI)

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Replaces the Medicare EHR Incentive Program (Meaningful Use)
- Greater flexibility in choosing measures
- Resource for details on Advancing Care Information: https://qpp.cms.gov/docs/QPP_ACI_Fact_Sheet.pdf
Select ACI Reporting Option

• In 2017, there are two measure options for reporting – ACI and 2017 ACI Transition

• Identify your EHR edition
  - 2014 vs. 2015 edition
  - Measures slightly different based on EHR edition

• Choose option for 2017 Transition measure set unless you have 2015 edition CEHRT that can report on full ACI measures

For a full list of measures, please visit QPP.CMS.gov/measures/aci
MIPS Category: Advancing Care Information (ACI)

• Fulfill the required measures for a minimum 90 days:
  - Security Risk Analysis
  - e-Prescribing
  - Provide Patient Access
  - Send Summary of Care
  - Request/Accept Summary of Care

• Choose to submit up to nine measures for a minimum of 90 days for additional credit

• **Bonus Credit** for public health and clinical data registry reporting measures
Meaningful Use in Medicaid

- MIPS applies to services under Medicare Part B. **MIPS does not** replace the Medicaid EHR Incentive Program, which continues through program year 2021.

- Clinicians eligible for Medicaid EHR Incentive Program will continue to attest to their state Medicaid agencies to receive their incentive payments.

- If those clinicians serve patients in Medicare Part B, they may also participate in MIPS.
MIPS Category: Improvement Activities

- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- Choose one to four activities from 90+ activities in nine subcategories:

<table>
<thead>
<tr>
<th>Expanded Practice Access</th>
<th>Population Management</th>
<th>Care Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Engagement</td>
<td>Patient Safety and Practice Assessment</td>
<td>Participation in an APM</td>
</tr>
<tr>
<td>Achieving Health Equity</td>
<td>Integrating Behavioral and Mental Health</td>
<td>Emergency Preparedness and Response</td>
</tr>
</tbody>
</table>

For a full list of activities, please visit QPP.CMS.gov/measures/ia
MIPS Category: Improvement Activities

Special status/considerations for:

<table>
<thead>
<tr>
<th>Participants in <strong>certified patient-centered medical homes</strong>, comparable specialty practices or an APM designated as a Medical Home Model: <strong>Automatically earn full credit</strong></th>
<th>Current participants in APMs, such as MSSP Track 1: <strong>Automatically receive points based on the model - full or half credit</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups with 15 or fewer participants, <strong>non-patient facing clinicians</strong> or those in a <strong>rural or health professional shortage area</strong>: <strong>Lesser requirements</strong> - attest that you completed two activities for a minimum of 90 days</td>
<td></td>
</tr>
</tbody>
</table>
### MIPS Category: IA Audit Documentation

<table>
<thead>
<tr>
<th>Activity ID</th>
<th>Subcategory Name</th>
<th>Activity Name</th>
<th>Activity Description</th>
<th>Activity Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_EPA_1</td>
<td>Expanded Practice Access</td>
<td>Provide 24/7 access to eligible clinicians or groups who have advice about urgent and emergent care</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

#### Validation
Functionality of 24/7 or expanded practice hours with access to medical records or ability to

#### Suggested Documentation (inclusive of dates during the selected continuous 90-day or year long reporting period)
1) Patient Record from EHR - A patient record from a certified EHR with date and timestamp indicating services provided outside of normal business hours for that
MIPS Category: Cost

- No reporting requirement; 0 percent of Final Score in 2017
- Clinicians assessed on Medicare adjudicated claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- Uses measures previously reported in the Quality and Resource Use Report (QRUR)
STEP 7 – UNDERSTAND YOUR QUALITY AND COST SCORES
Understand Quality & Cost through Quality Resource Use Report (QRUR)

- Do you have an Enterprise Identity Data Management (EIDM) account?
  - Yes: Continue below
  - No: Visit bit.ly/newEIDMacct

- Access your 2015 QRUR
  - Develop a quality improvement plan for measures below the national benchmark, high cost (spending) per beneficiary, hospital admissions for chronic conditions, and review attributed patients
  - bit.ly/QRURaccess
STEP 8 – PREPARE AUDIT DOCUMENTATION
Prepare Audit Documentation and Retain

- Consider source documents that demonstrate meeting MIPS objectives and measures
  - EHR Reports and Lists
  - Screen shots
  - Submission confirmations
  - Documentation for exclusions or special considerations
- Retain documentation for at least six years
STEP 9 – SUBMIT DATA BETWEEN JANUARY 1 AND MARCH 31, 2018
Deadline: March 31, 2018
Submission Info

- No mechanism for signing up – you simply submit data when the time comes
  - Exceptions – CMS web interface & CAHPS for MIPS
- Multiple options available
  - Carefully consider the options
- Some options and instructions for data submission are still under development (e.g., APIs)
- Picking measures and submission options are interconnected
Tips on Submission

- Registries – watch the dates, the registry may have deadlines due before the CMS submission deadline.
- EHRs – you can submit more measures than required. CMS will use the combination of measures which give you the **BEST** score. **TALK** to your **VENDOR** for specifics on submission.
- Claims reporting – **START NOW**.
Kick-off to your Action Plan

• Complete the Mountain-Pacific online QPP Assessment:

http://mpqhf.com/QIO/qpp-enroll/
Questions?
2018 and Beyond
Building a unified approach
Overview of eCQI
The Need for a New Approach

• The introduction of EHRs and other health information technology has changed the need for technical assistance for health care organizations (especially rural/small)

• Clinical best practices and clinical expertise are not enough to successfully drive quality improvement and improve outcomes

• Clinical quality improvement now requires both clinical and health information technology expertise
eCQI: Electronic Clinical Quality Improvement

• An approach that combines clinical best practices and technology expertise
• Optimizes health information technology (HIT) and standardized electronic data to achieve measurable improvement in quality of care
• Incorporates the data and functionality of your EHR into your quality improvement projects
• Health IT enabled Clinical QI (healthit.gov)  
  https://ecqi.healthit.gov/content/introduction-electronic-clinical-quality-improvement
eCQI: A Combination Approach

- EHR functionality:
  - Computer Provider Order Entry (CPOE)
  - Clinical Decision Support (CDS)
  - Patient portal/engagement
  - Patient panels/tracking/risk stratification
  - Health Information Exchange (HIE)
  - Interfaces and registries
  - Report utilities/population analytics

- Evidence-based clinical best practices
- Data tracking and analytics
- Proven quality improvement methodologies
Benefits of eCQI

- Align quality improvement efforts for greatest ROI and efficiency gains
- Reduce burden and duplication of effort between quality reporting/requirements
- Leverage EHR for advanced functionality and data tracking to improve outcomes and reduce manual tracking/chart abstraction
- Standardize processes and consistency through workflow analysis and staff education/training
- Focuses on achieving value added changes quickly and efficiently
- eCQI methodology can be applied to all quality improvement initiatives (is not quality program specific)
Clinical Decision Support (CDS)

- Target conditions and standardize treatments
  - Data Display
    - Flow sheets, patient data reports and graphic displays
  - Workflow Assistance
    - Task lists, patient status lists, integrated clinical and financial tools
  - Data Entry
    - Templates to guide documentation and structured data collection
  - Decision Making
    - Access to resources rule based alerts, clinical guidelines or pathways, patient/family preferences and diagnostic decision support
EHR Functionality for eCQI

• Patient education/discharge instructions
  - Provide credible source of information
  - Encourage patient engagement
  - Assist with transition of care

• Patient reminders
  - Proactive preventative care
  - Follow up and care coordination

• Lab interfaces (or lab results as structured data)
  - Data points retrieved from lab results
  - Lab results (structured data) enhances use of clinical decision support rules or guidelines at the point of care
EHR Functionality for eCQI

• Patient Panels/Risk Stratification
  - Track and monitor high risk patients
  - Use patient panels or risk scores to identify care coordination priorities
  - Track performance based on panels/risk scores

• HIE/Transition of Care/Discharge Info/Public Health Registries
  - Improve communication between providers and/or facilities
  - Provide and enhance continuity of care delivery
  - Data collection and analytics
  - Population health data
Focus on Structured Data

- Structured Data: If it is not documented in a discrete field, the system does not know it happened and cannot trigger the next event or report.
- You must use the recommended workflows and data entry points for the CQM reports from your EHR Vendor.
- Structured and standardized data is the foundation to interoperability:
  - Improve care coordination
  - Improve transition of care
  - Assist with risk stratification and reduction in total cost of care
Important Note!!!

Using the correct EHR workflows can ensure you get paid based on the actual quality of the care you are delivering.
When choosing eCQI projects

• Focus on return on investment opportunities (financial, efficiency gains, resource utilization, etc.)

• Review current quality program requirements, align project for biggest ROI or alignment across programs (CPC+, PCMH, Payer, etc.)

• If possible for MIPS, choose an eCQI project outcome or activity that benefits more than one MIPS category
MIPS & eCQI
MIPS eCQI Basic

1. Run the required Quality Measures and ACI reports (minimum 90 day period) to establish current performance
2. If possible, choose Quality Measures that align with other program requirements (PCMH, 1305, etc)
3. Compare current performance to benchmarks or goals
4. Review required workflows and data entry requirements for each measure - remind/retrain staff
5. Correct workflow entry should improve performance on measures – improving scores for both quality and ACI
MIPS: More Bang for the Buck

1. Perform steps identified in MIPS basic slides for Quality Measures and ACI measures
2. Choose Quality Measures that align with other program requirements (PCMH, etc)
3. Identify and eCQI project and follow the eCQI process
4. Choose a project that will improve Quality Measures, possibly get you bonus points for Advancing Care Information and will meet the Improvement Activity category requirements
MIPS: More Bang for Your Buck – Example 1

- Choose to report clinical quality measure CMS 50/ID 374 (closing the referral loop) for one of your Quality measures (it is a high priority measure)
- Use eCQI to improve your performance score (10th decile is 72 percent - EHR submission*)
- Can attest to IA– medium activity (care coordination IA_CC_1)
- Qualifies for a 10 percent ACI bonus

*check for current benchmark/submission methods
MIPS: More Bang for Your Buck – Example 2

• Choose to report clinical quality measure CMS123 /ID 163 (DM foot exams) for one of your Quality measures

• Use eCQI to improve your performance score (10th decile is 98 percent – registry, 76 percent for EHR*)

• Set up a clinical decision support (CDS) rule to enhance your workflow (alert for DM patients being seen who are due for a foot exam)

• IA– Medium – Use of clinical decision support ( IA_PSPA_16)

• Counts for ACI 10 percent bonus

*check for current benchmark/submission methods
MIPS: Adventurous – Examples

- eCQI project – Improve Care Coordination
  - Implement Medicare Transition of Care Management (TCM) billing code
    - Improve revenue
    - MIPS Quality – Closing the referral loop
    - ACI – Summary of care, clinical information reconciliation
    - IA – Care coordination, medication reconciliation, closing the referral loop, etc.

- eCQI – project – Antimicrobial Stewardship Program (ASP)
  - Work with HealthInsight/Mountain Pacific (QIN-QIOs) on ASP implementation
    - Several quality measures align
    - ACI – Patient education, clinical decision support
    - IA – Working with QIN-QIO, clinical decision support, medication reconciliation, patient education
The CMS Quality Payment Program website offers information on MIPS, including a fact sheet, multiple slide decks, in-depth information on the four MIPs components, scoring and more.

Website: QPP.CMS.gov
How to Contact a QPP Expert in Your State

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Please contact us for assistance!

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