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The Alphabet Soup of Clinical Quality Measure Reporting and Reimbursement: 2018 Updates

Bill Presley, Vice President

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Introductions

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- William Presley, Vice President , Acmeware

Acronyms in this Presentation

ACA - Affordable Care Act

ASCQR - Ambulatory Surgical Center Quality Reporting

ARRA - American Recovery and Reinvestment Act

CEHRT - Certified Electronic Health Record Technology

eCQM - Electronic Clinical Quality Measures

HAI - Healthcare-Associated Infection

HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems

IACS - Individuals Authorized Access to the CMS Computer Services

IPFQR - Inpatient Psychiatric Facilities Quality Reporting

IPPS - Inpatient Payment Prospective System

IQR - Inpatient Quality Reporting

NHSN - National Healthcare Safety Network

MU – Meaningful Use EHR Incentive Program

OPPS - Outpatient Prospective Payment System

OQR - Outpatient Quality Reporting

PCCEC - Patient and Caregiver-Centered Experience of care/Care Coordination

PCHQR - PPS-Exempt Cancer Hospital Quality Reporting

VBP – Value-Based Purchasing

Agenda

- Quality Payment Reporting Initiatives
- Clinical Quality Measure Alignment
- Compare and Contrast Reporting Requirements
- Proposed Programs
- Helpful Resources

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CMS Guiding Principles

- Patient Centric
- Clinician Driven
- Simplification

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Quality Payment Programs

CMS "All Seeing Eye"

Hospital Quality	Physician Quality Reporting	PAC and OTHER Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program	• Medicare and Medicaid EHR Incentive Program	• Inpatient Rehabilitation Facility	• Medicare Shared Savings Program	• Medicaid Adult Quality Reporting
• PPS-Exempt Cancer Hospitals	• Physician Quality Reporting System (PQRS)	• Nursing Home Compare Measures	• Hospital Value-based Purchasing	• CHIPRA Quality Reporting
• Inpatient Psychiatric Facilities	• Value-based Payment Modifier (VM)	• LTCH Quality Reporting	• Physician Feedback	• Health Insurance Exchange Quality Reporting
• Inpatient Quality Reporting	• Maintenance of Certification	• Hospice Quality Reporting	• ESRD QIP	• Medicare Part C
• HAC Payment Reduction Program		• Home Health Quality Reporting	• Innovations Pilots	• Medicare Part D
• Readmission reduction program				
• Outpatient Quality Reporting				
• Ambulatory Surgical Centers				

= Public Reporting Focus for Hospitals/ CAHs/ Eligible Providers

http://www.cms.gov/eHealth/downloads/eHealthU_PQRSQualityManagement101.pdf

Vision for Quality Reporting

One Spec to rule them all, One Spec to find them,

One Spec to bring them all and in the darkness bind them

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Vision for Quality Reporting

Unified and **aligned set** of clinical quality measures and reporting requirements to synchronize and integrate CMS quality programs which will reduce reporting burden and improve on patient outcomes.

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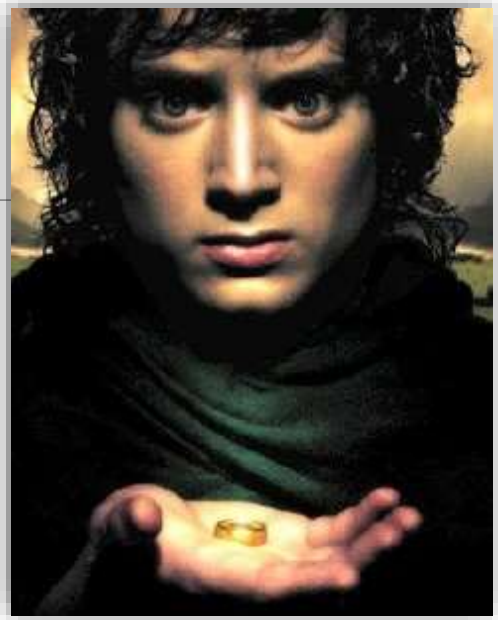
Quality Reporting Direction



The Future - One Specification

Core Measures (Chart Abstraction)

- Manual Chart Abstracted
- Paper-based specifications
- Translated to CMS Specification Manual

Clinical Quality Measure (eCQM)

- Electronically Captured
- Measure Concepts
- Electronic Codification
- Electronic Specification
- eCQM Library (One Spec)

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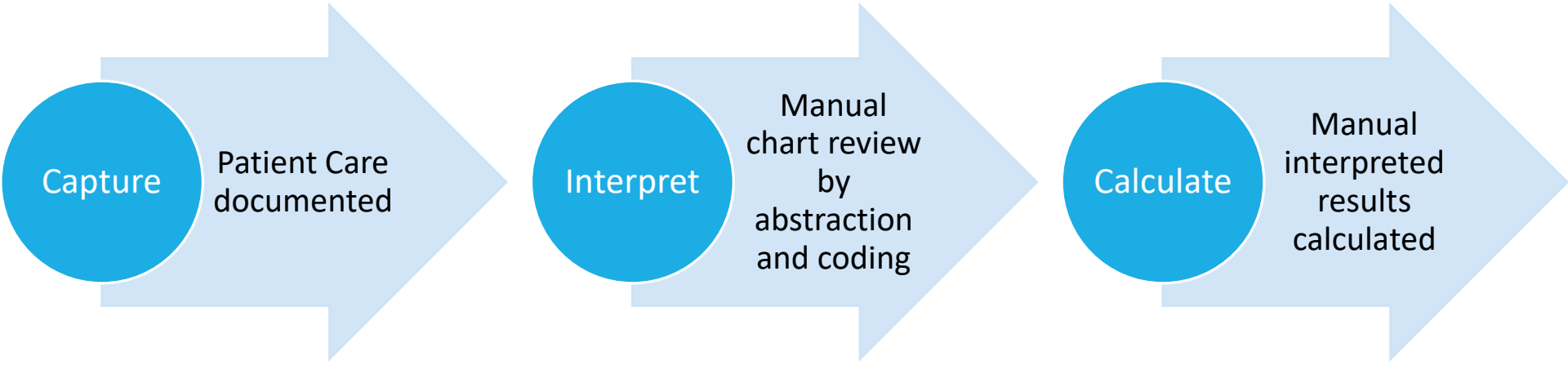
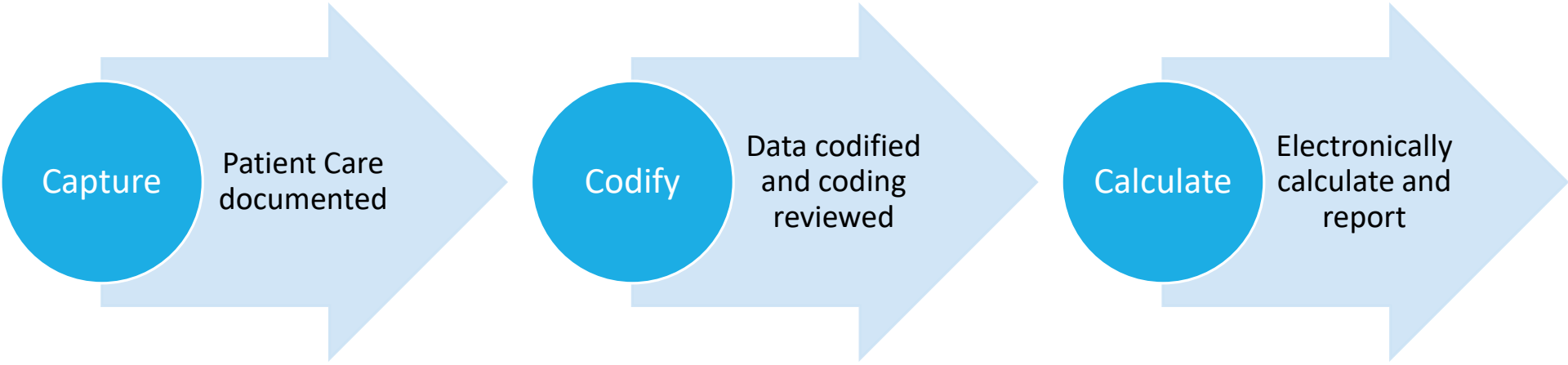
Human vs Machine

Manual Abstraction Process



Human vs Machine

Electronic Measure Process



Electronic Measures vs Manual Abstraction

Specifications Manual

- The Specifications Manual for National Hospital Inpatient Quality Measures
- Uniform set of national hospital quality measures
- Paper tools for use in abstracting data for each collection (discharge) period are provided with the Specifications Manual

eCQM Library

Electronically specified versions of traditionally chart-abstracted Clinical Quality Measures

Developed specifically so Certified Electronic Health Record Technology (CEHRT) can capture, calculate, export, and transmit the measure data

For eReporting of eCQMs to demonstrate meaningful use or for Quality Reporting Programs

Data Collection Period	Specifications Manual
10/01/15 - 06/30/16	Version 5.0
01/01/15 - 09/30/15	Version 4.4a
01/01/14 - 12/31/14	Version 4.3b

Reporting Year	eCQM Specifications
2016	May 2015 Update
2015	April 2014 Update
2014	April 2013 Update

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Hospital Quality Reporting Reductions

Year	IQR	EHR MU	VBP	HAC	HRRP
2013	2.0% MBU	N/A	1.0% DRG	N/A	1.0% DRG
2014	2.0% MBU	N/A	1.25% DRG	N/A	2.00% DRG
2015	0.25% MBU	0.25% MBU	1.50% DRG	1.0% DRG	3.00% DRG
2016	0.25% MBU	0.50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	0.25% MBU	0.75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

MBU = Market Basket Update
DRG = Diagnosis-related group

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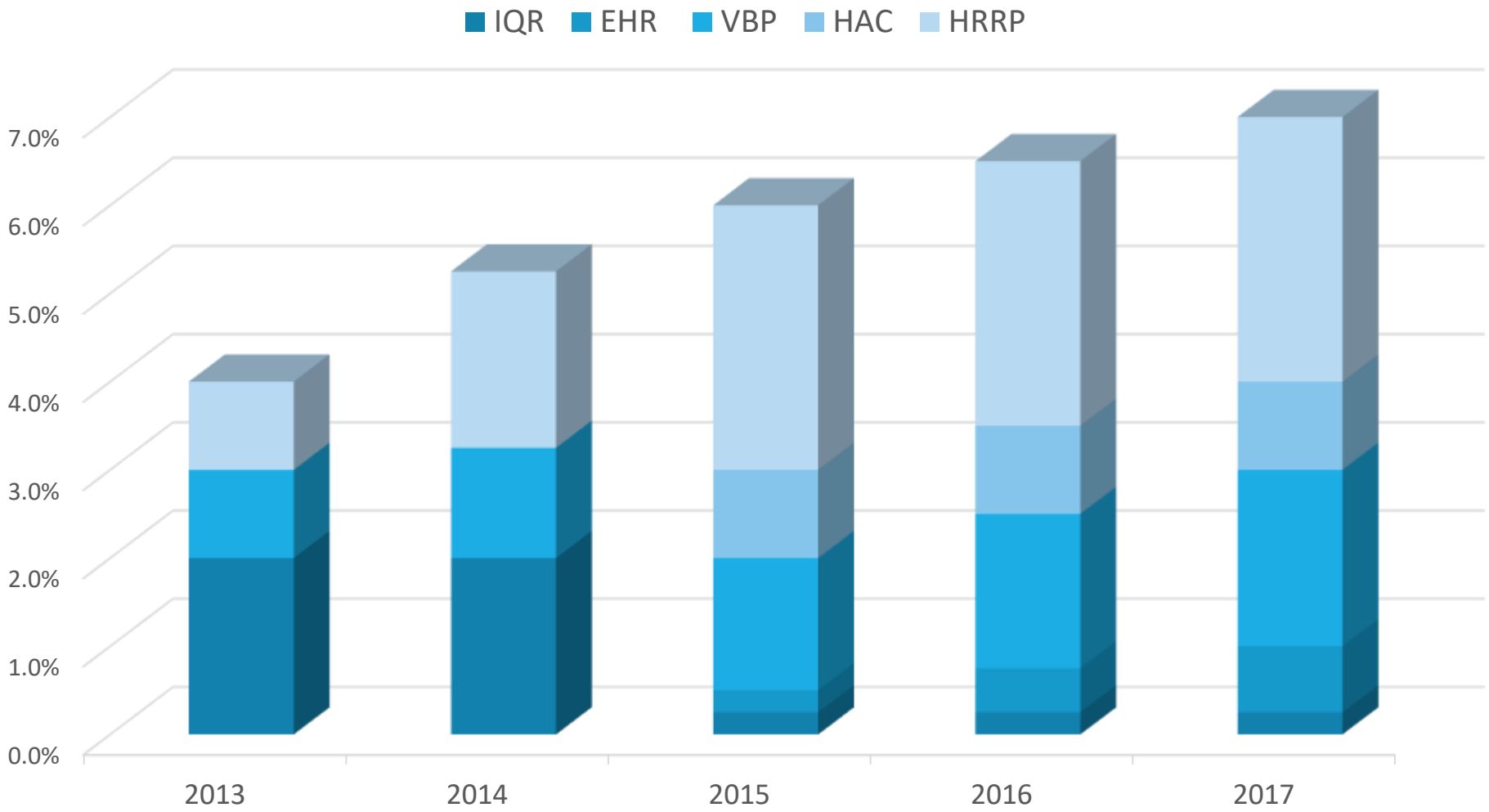
Hospital Quality Reporting Reductions



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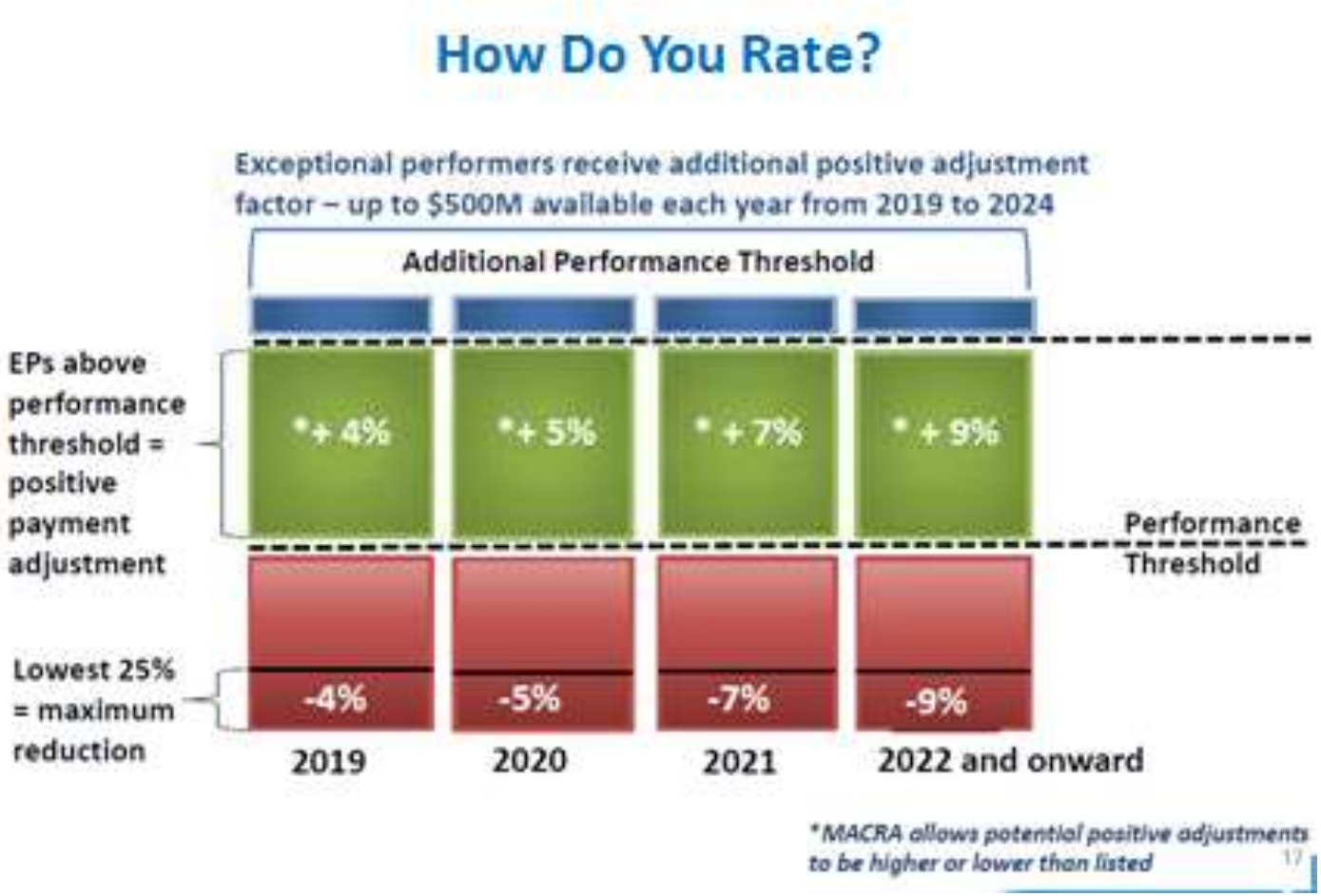
Physician Quality Reporting Reductions



IQR

INPATIENT QUALITY REPORTING

IQR Purpose

- Provide hospital transparency about quality and safety
- Provide consumers (us) with quality of care information to make better decisions
- Publish on CMS Hospital Compare website
- Resulting in improved quality of inpatient care to all patients
- Provides incentives to report quality of care measures

IQR Background

- Medicare Modernization Prescription Drug, Improvement and Modernization Act (MMA) of 2003
  - Non-submission would result in a 0.4 % reduction in APU
- Deficit Reduction Act of 2005
  - Non-submission would result in a 2.0 % reduction in APU
- CMS issued the 2014 Inpatient Prospective Payment System (IPPS) final rules to align IQR with eCQM.
- CMS issued the 2016 Inpatient Prospective Payment System (IPPS) mandating eCQM for IQR program.

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IQR Penalties

- Social Security Act, starting in FY 2015, penalized hospitals that fail to submit quality information.

Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

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IQR Requirements

- Create CMS Portal and QualityNet Administrator Accounts
- Complete the Hospital IQR Program Notice of Participation
- Collect and report data:
  - Clinical data
  - HCAHPS data
  - HAI measures reported through NHSN
  - Structural measures
  - Data Accuracy and Completeness Acknowledgement
- Meet validation requirements
- Quality data published to Hospital Compare (not eCQMs)

IQR Resources

CMS Enterprise Portal

https://portal.cms.gov

Hospital Compare

www.medicare.gov/hospitalcompare

Quality Reporting Center

http://www.qualityreportingcenter.com

QualityNet

www.qualitynet.org

MU

EHR INCENTIVE PROGRAM

"MEANINGFUL USE"

EHR Incentive Program Purpose

- Known as “Meaningful Use”, provides Medicare and Medicaid incentive payments to qualifying physicians and hospitals, when they adopt and use Certified Electronic Health Record Technology (CEHRT)
- CEHRT adoption promotes:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and their families
  - Improve care coordination
  - Ensure adequate privacy and security protections for personal health information
  - Improve population and public health

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EHR Incentive Program Background

- The American Recovery and Reinvestment Act (ARRA) established in 2009, a framework of financial incentives to stimulate growth and improve the health care system.
- CMS published Meaningful Use CEHRT regulations in:
  - Stage 1 Final Rule published July 2010
    - http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
  - Stage 2 Final Rule published September 2012
    - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html
  - Stage 3 Final Rule published October 2015
    - https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications

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EHR Incentive Program Penalties

- Payment adjustment amounts are tied to the year hospitals do not demonstrate meaningful use.
- Payment adjustment is tied to the percentage increase for the Inpatient Prospective Payment System (IPPS) rate.
- Hospitals that do not meet meaningful use in 2018 will receive a 75% reduced update.

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EHR Incentive Program Requirements

- Utilization of certified EHR technology (CEHRT)
- Value Set Nomenclature Mapping
- Submission of objective measures and electronic clinical quality measures (eCQM)
- Submission of clinical quality measure data:
  - Option 1: Aggregate reporting of numerators and denominators in the CMS Registration and Attestation system
  - Option 2: Submission of QRDA files to QualityNet

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EHR Incentive Program Penalties

Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

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EHR Incentive Program Resources

National Library of Medicine

http://www.nlm.nih.gov/healthit/meaningful_use.html

eCQM Library

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

eCQI Resource Center

https://ecqi.healthit.gov

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ORYX

THE JOINT COMMISSION PERFORMANCE MEASURES PROGRAM

ORYX Program Purpose

- The Joint Commission's ORYX® initiative integrates outcomes and other performance measurement data into the accreditation process.
- ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts.
- ORYX measures are publicly reported on The Joint Commission website at www.qualitycheck.org.

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ORYX Program Background

- Hospitals began reporting core measures nearly 15 years ago as part of hospital accreditation by the Joint Commission.
- In 1999, the first ORYX data transmitted to the Joint Commission from hospitals and long term care organizations.
- In 2007, added seven hospital outpatient measures to core measure sets to satisfy ORYX performance measurement requirements.
- New in 2015, offered Hospitals greater flexibility in meeting ORYX performance measures with eCQM reporting.

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ORYX Program Requirements

- As of 2015, Core measures have been aligned with CMS eCQM Specifications.
- Perinatal care will remain mandatory in 2016 for hospitals with at least 300 live births per year.
- Approved ORYX Vendor for Chart Abstraction or eCQM.

ORYX Program Requirements

2017 ORYX Performance Measure Reporting Requirements

Hospital Accreditation Program Requirements

Chart-Abstracted Measures

Select and Report Data on:

- **Five chart-abstracted measures** applicable to the services provided and patient populations served by the hospital.

Joint Commission Chart Abstracted Measures
ED-1, ED-2
PC-01*
VTE-6
IMM-2

- ***Four Additional Perinatal Care measures** (PC-02, PC-03, PC-04, PC-05) are required for health care organizations with at least 300 live births per year.
- Collect and report data quarterly for calendar year (CY) 2017.
- May elect to report on additional measures relevant to services provided and patient populations served by the hospital – See Joint Commission measures effective January 1, 2017.

Please note: The Joint Commission has not adopted the CMS "sepsis management bundle" (SEP-1) for 2017.

AND

Electronic Clinical Quality Measures (eCQMs)

Select and Report Data on:

- **Six of thirteen available eCQMs** applicable to the services provided and patient populations served by the hospital.

Joint Commission eCQM Measures
eAMI-8a
eCAC-3
eED-1, eED-2
ePC-01, ePC-05
eSTK-2, eSTK-3, eSTK-5, eSTK-6
eVTE-1, eVTE-2
eEHDI-1a

- Report 4 quarters of data for calendar year (CY) 2017 by the annual submission date (3/15/2018).
- May elect to report on additional eCQMs relevant to services provided and patient populations served by the hospital – See Joint Commission measures effective January 1, 2017.

ORYX Program Resources

The Joint Commission

http://www.jointcommission.org

ORYX Program

http://www.jointcommission.org/facts_about_oryx_for_hospitals/default.aspx

Pioneers in Quality

https://www.jointcommission.org/topics/pioneers_in_quality.aspx

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VBP

VALUE-BASED PURCHASING

VBP Program Purpose

- Required by the Affordable Care Act for IPPS hospitals; quality payment program
- Moving toward rewarding better value, outcomes, and innovations, instead of volume
- Promote better clinical outcomes for hospital patients
- Improve patient experience of care during hospital stays

VBP Program Background

- Funded by reductions from Diagnosis-Related Group (DRG) payments; Budget Neutral
- Built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
- Measures collected through the Hospital IQR Program infrastructure
- Reimbursements based on either national benchmarks or internal improvements

VBP Program Domains and Measures

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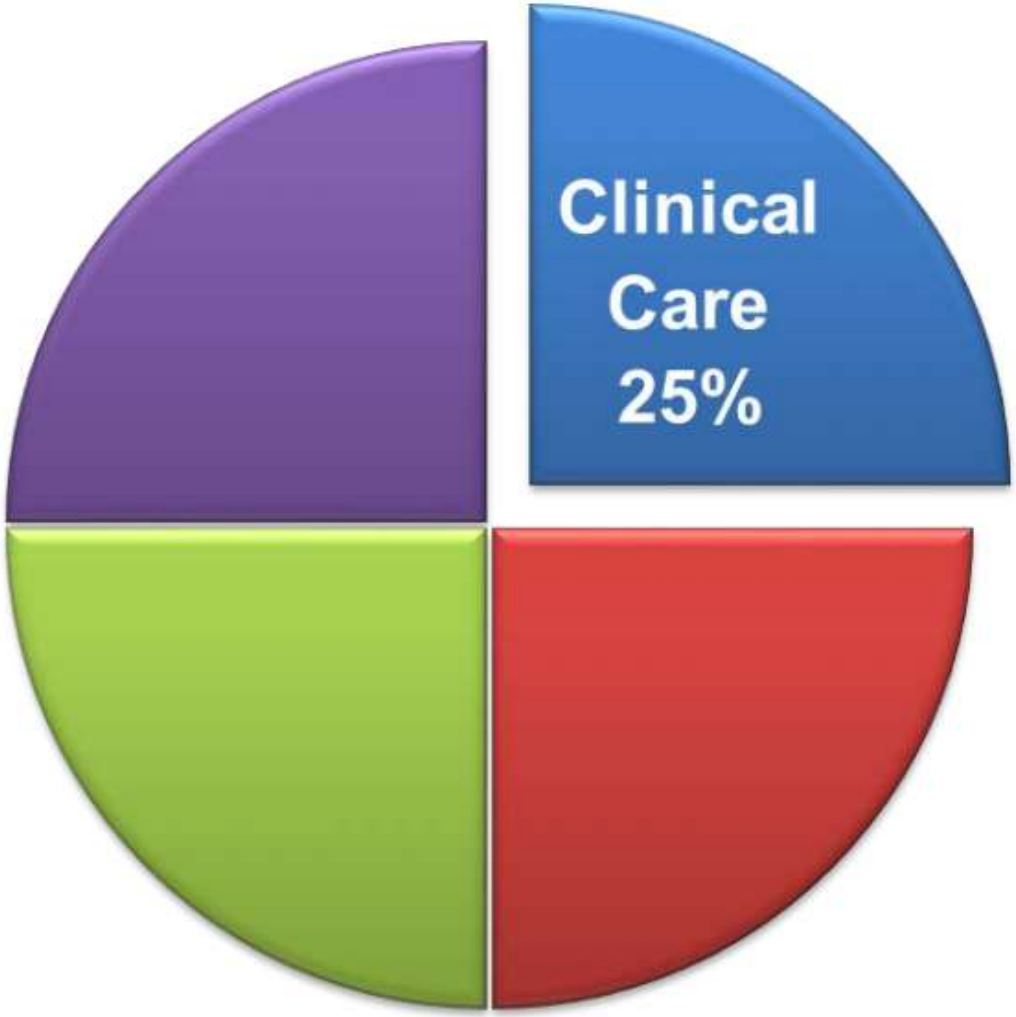
VBP Program Domains and Measures

MORT-30-AMI:
Acute Myocardial Infarction (AMI)
30-Day Mortality Rate

MORT-30-HF:
Heart Failure (HF)
30-Day Mortality Rate

MORT-30-PN:
Pneumonia (PN)
30-Day Mortality Rate

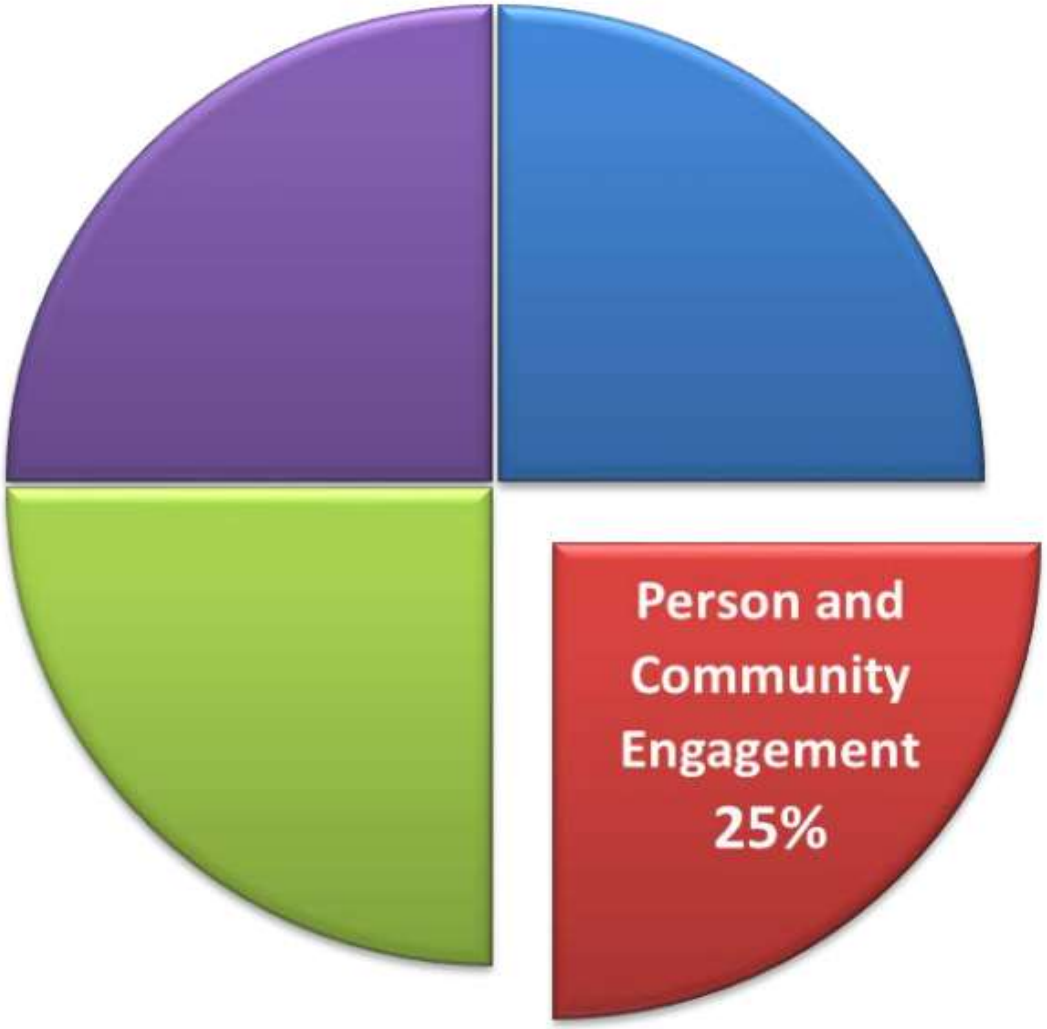
THA/TKA:
Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
Complication Rate



VBP Program Domains and Measures

HCAHPS Dimensions:

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Communication about Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital
- Care Transition



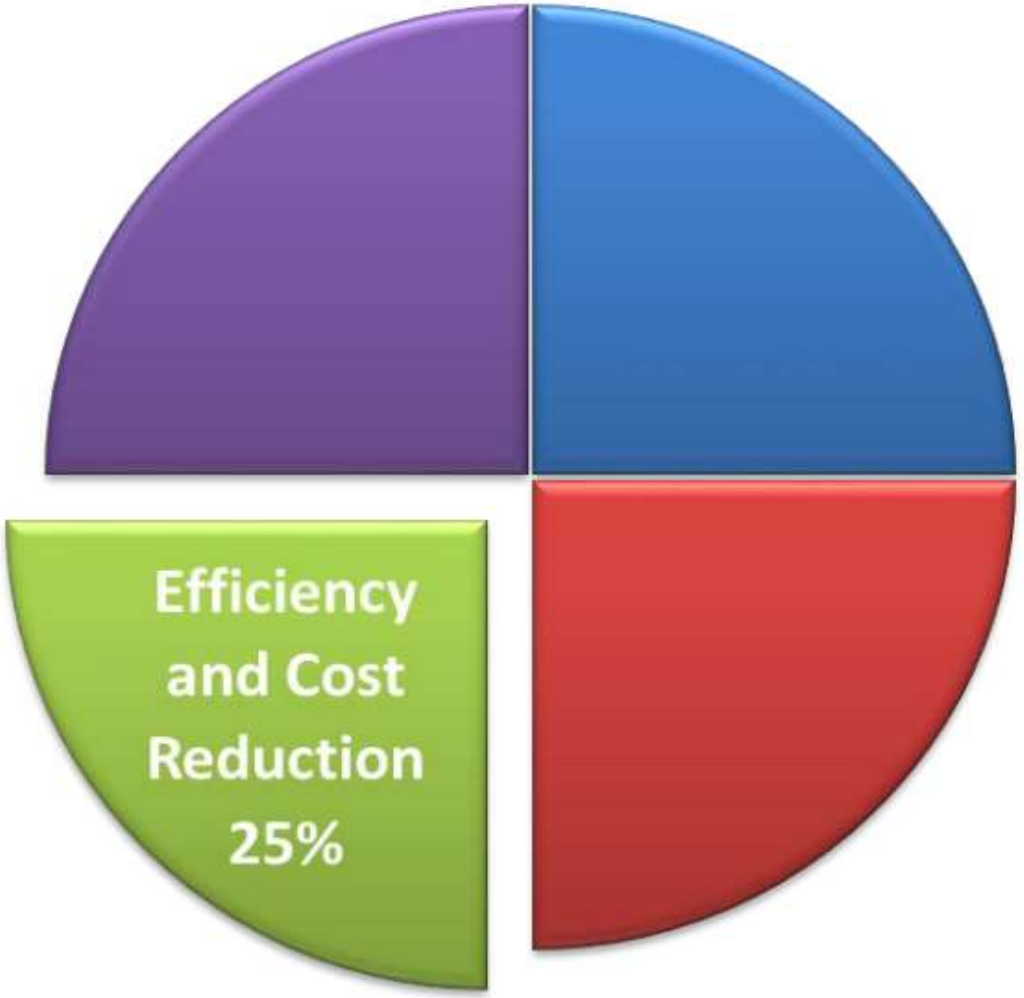
VBP Program Domains and Measures

PSI-90: Complication/patient safety for selected indicators (composite)
CLABSI: Central line-associated blood stream infections
CAUTI: Catheter-associated urinary tract
infections
SSI: Surgical site infections specific to abdominal hysterectomy and colon surgery
MRSA: Methicillin-Resistant Staphylococcus
aureus Bacteremia
CDI: Clostridium difficile Infection
PC-01: Elective Delivery prior to 39 Completed Weeks of Gestation

VBP Program Domains and Measures

MSPB: Medicare
Spending by Beneficiary:

- Claims-Based Measure
- Includes risk-adjusted and price-standardized payments for Part A and Part B services provided three days prior to hospital admission through 30 days after hospital discharge



Value Based Purchasing Scoring

- Scores for all measures generate total performance score
- Types of points awarded
  - Achievement points
    - 0-10 based on comparison to all hospitals' baseline period rates
  - Improvement points
    - 0-9 based on comparison to same hospital's baseline period rates
  - Consistency points
    - 0-20 based on hospital's HCAHPS scores compared to all hospitals' baseline period rates

Financial Impact

- Total amount of value-based incentive payments must equal the total amount withheld across all hospitals in the program.
- For FY19 payment (2017 performance): 2% withhold
- Value-based incentive payments = Sum of all hospital's base-operating DRG*0.02 (withhold)

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VBP Program Penalties

Reimbursement = Achievement + Improvement

Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

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VBP Program Resources

Quality Reporting Center

http://www.qualityreportingcenter.com/inpatient/vbp-archived-events

CMS VBP

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html

QualityNet

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937

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HRRP

HOSPITAL READMISSIONS REDUCUTION PROGRAM

HRRP Program Purpose

- The Affordable Care Act (ACA) established the Hospital Readmissions Reduction Program (HRRP).
- Requires the CMS to adjust payments to hospitals with excess unplanned readmissions for certain conditions.
- Aims to improve the quality of care by improving communication and care coordination, while reducing the costs.

HRRP Program Background

- According to CMS, historically about one in five Medicare patients discharged from a hospital are readmitted within 30 days.
- In 2005, the Medicare Payment Advisory Commission (MedPAC) concluded that about three-quarters of readmissions within 30 days were preventable.
  - Estimated at $12 billion in Medicare spending.

HRRP Program Requirements

Readmission Measures	2013	2014	2015	2016	2017
Acute myocardial Infarction	✓	✓	✓	✓	✓
Heart failure	✓	✓	✓	✓	✓
Pneumonia	✓	✓	✓	✓	✓
Chronic obstructive pulmonary disease			✓	✓	✓
Total hip arthroplasty/ Total knee arthroplasty			✓	✓	✓
Coronary artery bypass graft surgery					✓

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HRRP Program Penalties

- Hospitals below national average for any one of the conditions are subject to a payment adjustment.
- Payment adjustment applies to all Medicare discharges for that year, not just a hospital's readmissions.

Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

HRRP Program Resources

QualityNet Program

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458

CMS Acute IPPS

https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

Quality Reporting Programs

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html

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HAC

HOSPITAL ACQUIRED CONDITIONS

HAC Program Purpose

- The Affordable Care Act (ACA) established the HAC Reduction Program to incentivize hospitals to reduce hospital-acquired conditions (HACs)
- Payment adjustments to discharges started in FY 2015
- Payment adjustments for lowest performing quartile
- Improve patient outcomes with quality measurements

HAC Program Background

- Applies to hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS)
- Program does not affect:
  - Long-term acute care hospitals
  - Cancer hospitals
  - Children's hospitals
  - Inpatient rehab facilities
  - Inpatient psychiatric facilities
  - Critical access hospitals

HAC Program Requirements

HAC Measures	2015	2016	2017
Patient Safety Indicator (PSI) 90 Composite	✓	✓	✓
Central line-associated bloodstream infection (CLABSI)	✓	✓	✓
Catheter associated urinary tract infection (CAUTI)	✓	✓	✓
Surgical site infection (SSI) (colon and hysterectomy)		✓	✓
Methicillin-resistant Staphylococcus (MRSA)			✓
Clostridium difficile (C.diff)			✓

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HAC Program Penalties

- Reduce hospital payments by 1 percent for hospitals that rank among the lowest-performing 25 percent.
- All hospitals receive between 1 and 10 points per measure - Higher Score = Worse Performance
- 1% penalty to any hospital that falls into the bottom 25%

Year	IQR	EHR MU	VBP	HAC	HRRP
2016	25% MBU	50% MBU	1.75% DRG	1.0% DRG	3.00% DRG
2017	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2018	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG
2019	25% MBU	75% MBU	2.00% DRG	1.0% DRG	3.00% DRG

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HAC Program Resources

Quality Reporting Programs

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions.html

Hospital Compare

www.medicare.gov/hospitalcompare/HAC-reduction-program.html

QualityNet HAC Reduction Program

www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166

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OQR

OUTPATIENT QUALITY REPORTING

OQR Program Purpose

- The Hospital Outpatient Quality Reporting (OQR) Program is a quality measure reporting program implemented by the CMS for outpatient hospital services
- Starting CY 2009, Hospitals report data using standardized measures of care to receive the full annual update to their Outpatient Prospective Payment System (OPPS) rate
- Pay for quality data reporting program

OQR Program Background

- CMS publicly reports Hospital OQR data
- OQR Program is modeled after the IQR Program
- OQR Program is a voluntary for outpatient hospital services
- OQR focuses on quality measures that have a high impact and improved quality and efficiency.
  - process of care, imaging efficiency patterns, care transitions, ED throughput efficiency, use of Health Information Technology (HIT) care coordination, patient safety and volume.

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OQR Program Requirements

- Measures submitted on QualityNet
- Clinical data submission is accomplished in one of two ways:
  - CMS Abstraction & Reporting Tool (CART)
  - Third party vendor
- Hospitals measurements published to Hospital Compare
- CMS is considering a proposal for eCQM submissions

Timeline for 2016

Specifications Manual	Implementation Date (for encounters beginning)	Projected Date for Specifications Manual and Release Note Updates
January 2016	01/01/2016	07/01/2015 (180 Days prior to release)
July 2016	07/01/2016	01/01/2016 (180 days prior to release)
January 2017	01/01/2017	07/01/2016 (180 days prior to release)
July 2017	07/01/2017	01/01/2017 (180 days prior to release)

OQR Program Penalties

- Hospitals that meet measure reporting requirements during a calendar year to receive their full OPPS reimbursements
- Fail to meet these requirements receive a 2% reduction of their APU

OQR Program Resources

Hospital OQR Program

www.qualityreportingcenter.com

Quality Reporting Center

http://www.qualityreportingcenter.com/hospitaloqr

OQR Measures

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1192804531207

Hospital OQR ListServe

www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register

MACRA/MIPS

MERIT-BASE INCENTIVE PAYMENT SYSTEM

MACRA Background

- Bipartisan legislation signed into law on April 16, 2015
- Repealed Sustainable Growth Rate Formula
- Rewards providers for quality versus quantity
- Combines existing quality programs into one
- Participants: Part B Eligible Professionals

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MIPS Background

- Combines components of PQRS, Value Modifier, and MU into one program
- One composite performance score, 0-100 points, determined through 3 weighted categories
- Budget neutral program rewarding quality performance
  - 2017 performance impacts 2019 payment

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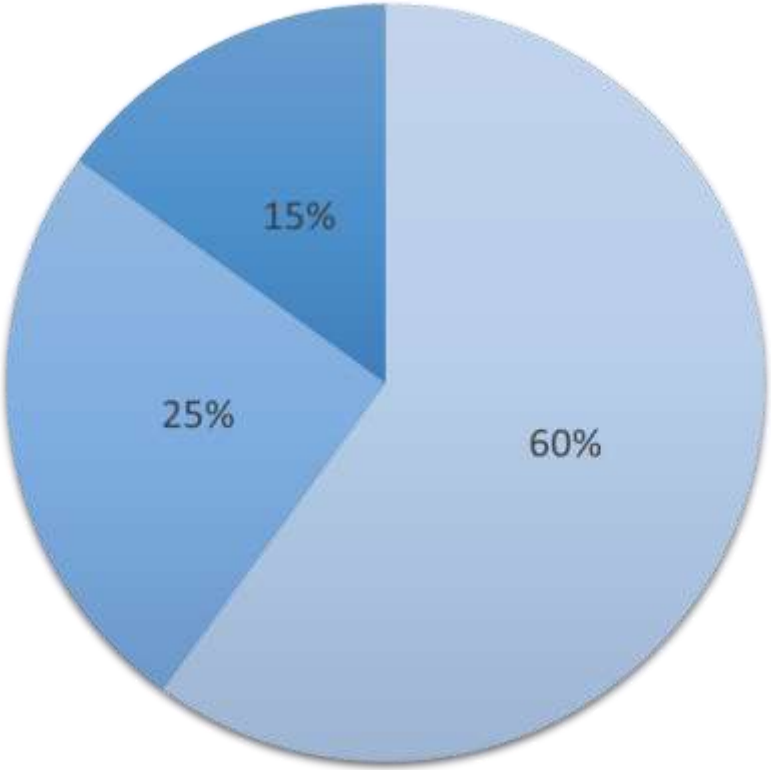
MIPS Categories: 2017 Weights

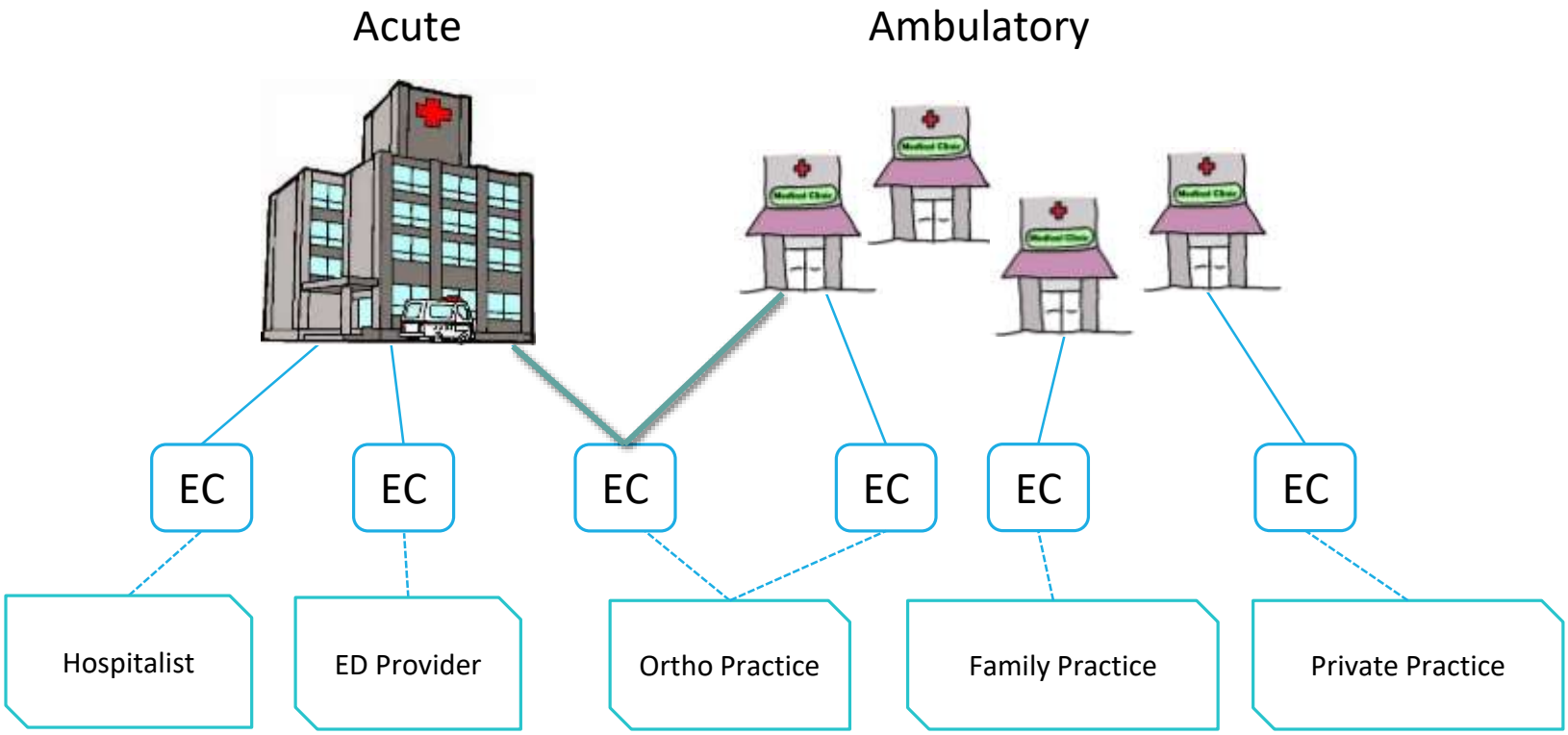
Improvement
Activities
New category.



Advancing Care Information
Replaces the Medicare EHR Incentive Program also known as Meaningful Use.

Quality
Replaces the Physician Quality Reporting System (PQRS).

MIPS Eligibility



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MIPS Participation Options

	Pick Your Pace	
	Option 1 (Crawl) Test the System by submitting partial data (1 Quality Measure OR 1 IA OR Base ACI Measures)	Avoid negative payment adjustment in 2019
	Option 2 (Walk) Participate for Part of the Year (minimum 90 days)	Neutral or small positive payment adjustment in 2019
	Option 3 (Run) Participate Full Calendar Year	Modest payment adjustment in 2019

Meaningful Use vs Advancing Care

Meaningful Use	Advancing Care
• Strict Reporting Requirement • Labor Intensive • Misaligned with Other Quality programs	• Flexible Reporting • Streamlined • Aligned with Other Quality Programs

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Advancing Care Information Objective Measures

Required Objective Measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
  - Timely access, access via application of choice - API
- Send Summary of Care
- Request/Accept Summary of Care

Advancing Care Information Transition Objective Measures

Required Objective Measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
  - Timely access only
- Send Summary of Care

Improvement Activities

15% of Total MIPS Score

Minimum of 1 must be selected

Maximum Score of 40 points

Credit for involvement in Medical Home and APMs

90 available to accommodate specialists

Description of Improvement Activities

90 available aligned with:

- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Expanded Practice Access
- Population Management
- Emergency Preparedness
- Achieving Health Equity
- Participation in APM

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Improvement Activities: Scoring

Scoring based on weighting

- Up to 20 points for highly weighted activities
  - Medical Home, transformation of the clinic, public health priorities
  - Examples: Patient experience ratings, timely access for Medicaid patients
- Up to 10 points for all other activities, considered medium weight. Most options are of medium weight

Total high weight points + total medium points/total possible points (40) = % of Improvement Activities Score

Improvement Activities: Reporting

Individual clinicians, groups or designated 3rd party vendors must designate Yes/No to each chosen activity

Reporting Options:

- Attestation
- QCDR
- Qualified Registry Reporting
- EHR
- Claims (If feasible, no other reporting necessary)
- Groups of 25 or greater also have option of reporting via CMS Web Interface

Cost Catagory

0% of total MIPS score

Replaces Value Modifier

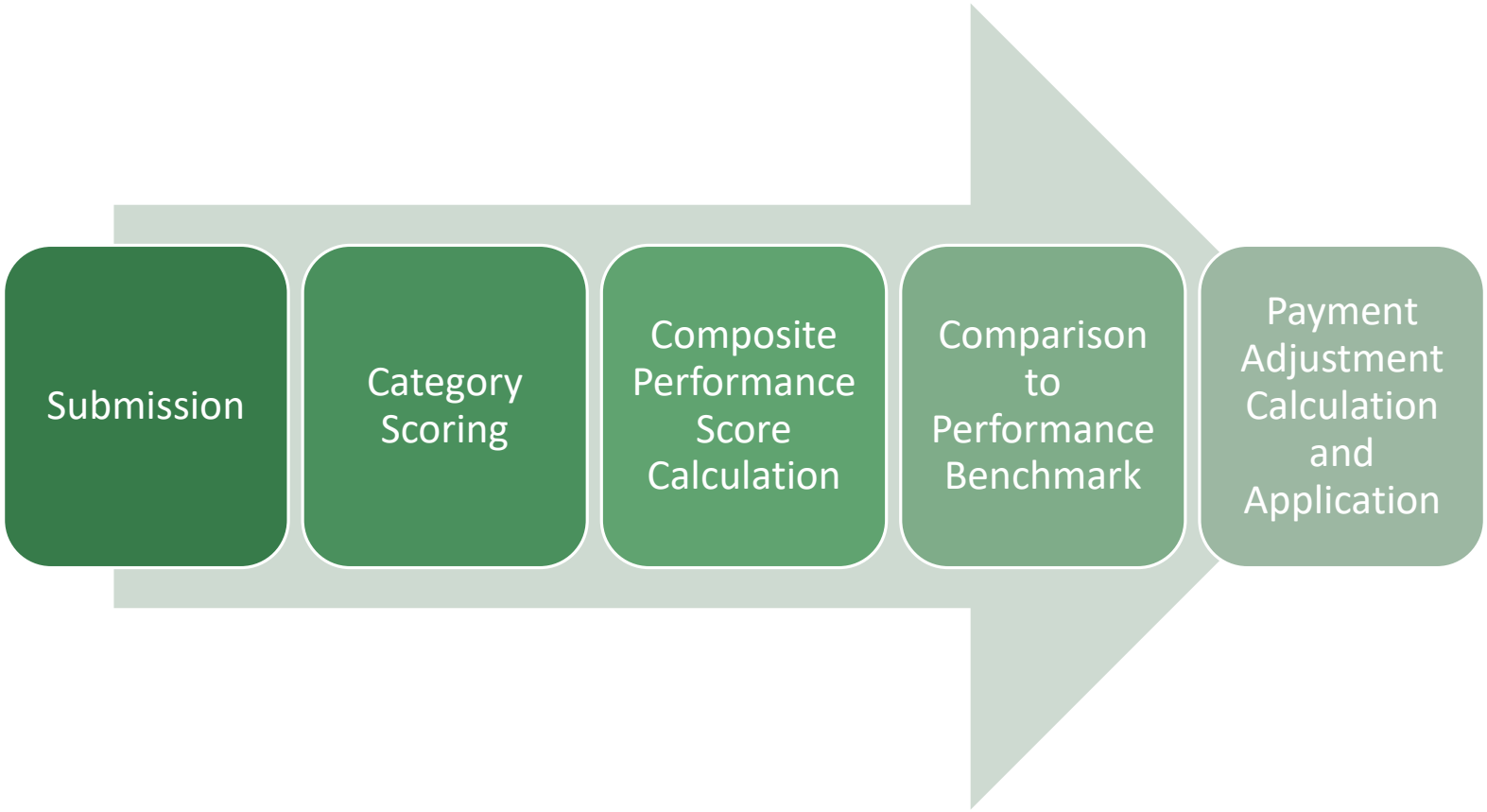
Claims based reporting

*No additional reporting requirements

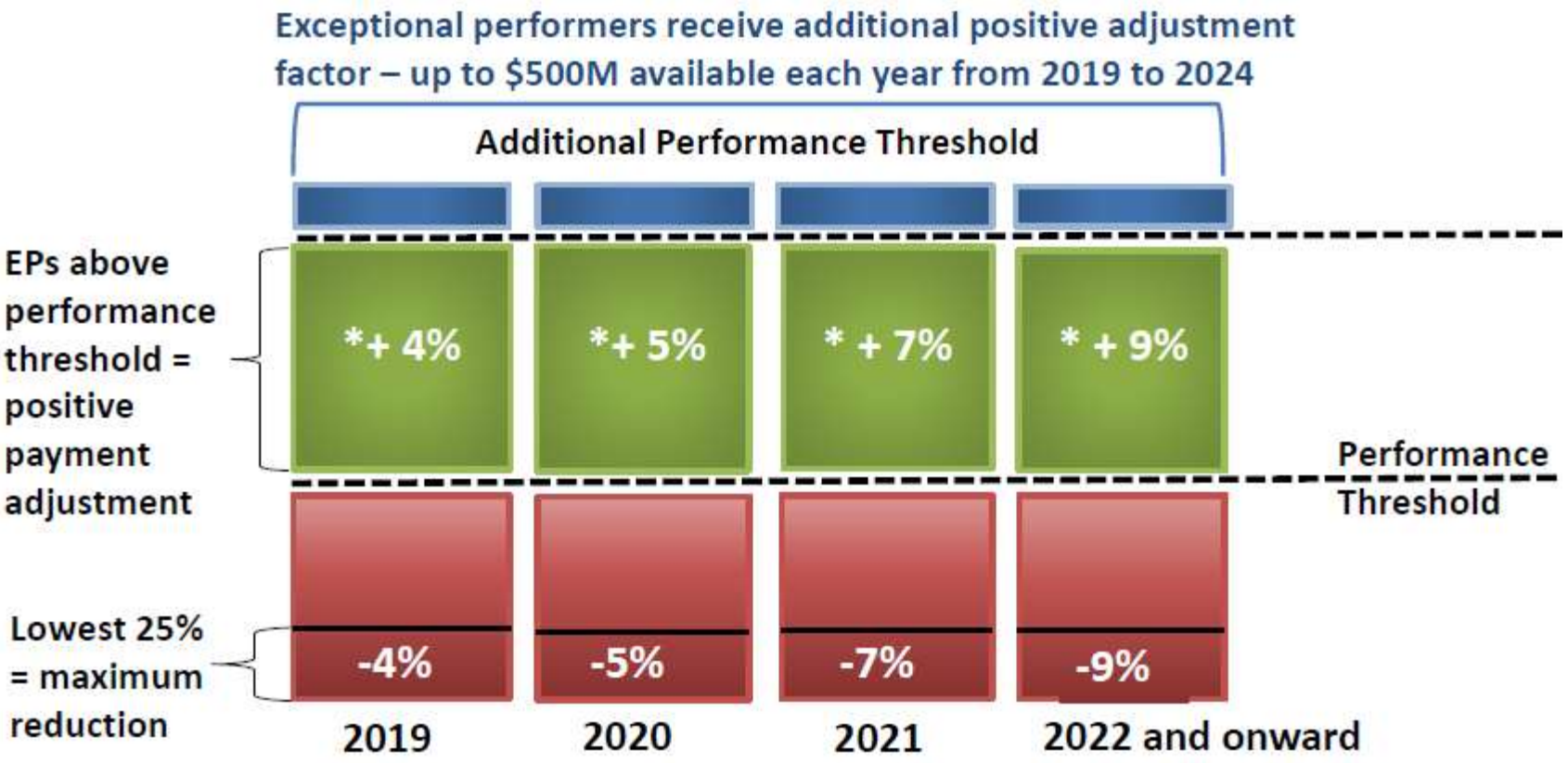
Scoring is based on comparison to others

*Those that provide the most efficient, effective care will receive greater scores

Total Performance Score



How Do You Rate?



*MACRA allows potential positive adjustments to be higher or lower than listed

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MACRA/MIPS Program Resources

QualityNet PQRS

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1187820137434

eCQM Reporting

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Electronic-Health-Record-Reporting.html

CMS Website

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/

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The Future of Quality Reporting

We Hates It!

- 2016 Inpatient Prospective Payment System (IPPS) Rule mandates eCQM
- 2016 IPPS eCQM Submission Requirements for IQR
  - 4 eCQMs reflecting Q3 or Q4 CY 2016
- In 2015 Joint Commission issued guidance that they were transitioning from Core Measures to CMS eCQM Specifications
- Outpatient Quality Reporting Program (OQR) has a proposed 2017 eCQM requirement
- Comprehensive Primary Care Initiatives have embedded eCQM submission into their reporting options

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Prepare Now for eCQM

No, no…We Loves It!

What are eCQMs?

- Electronically specified versions of traditionally chart-abstracted Clinical Quality Measures
- Developed specifically so Certified Electronic Health Record Technology (CEHRT) can capture, calculate, export, and transmit the measure data
- Electronic Codification of Patient Health Record

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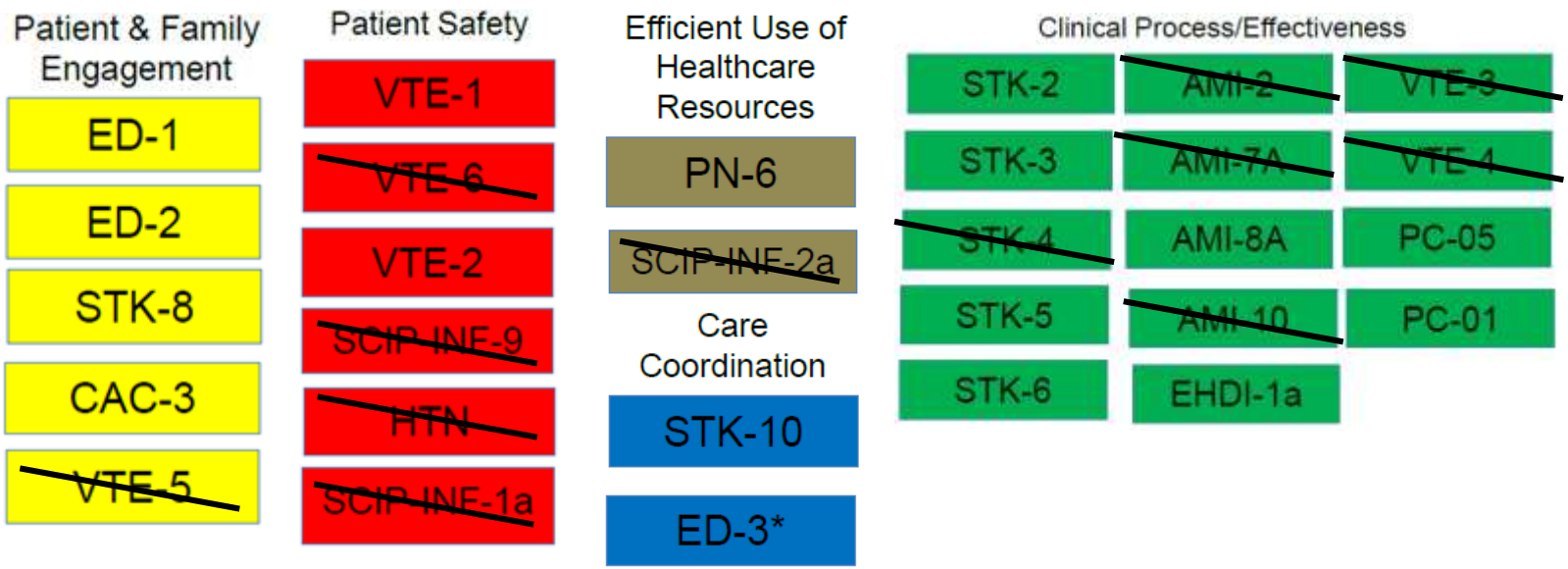
2017 IPPS Proposal - eCQMs Removed

- Meaningful Use (MU)
- Inpatient Quality Reporting (IQR)



* Excluded from IQR and ORYX

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Finalized List of eCQMs for 2017

- AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
- CAC-3 - Home Management Plan of Care Document Given to Patient/Caregiver
- ED-1 - Median Time from ED Arrival to ED Departure for Admitted ED Patients
- ED-2 - Admit Decision Time to ED Departure Time for Admitted Patients
- EHDI-1a - Hearing Screening Prior to Hospital Discharge 1354
- PC-01 - Elective Delivery
- PC-05 - Exclusive Breast Milk Feeding
- STK-02 - Discharged on Antithrombotic Therapy
- STK-03 - Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-05 - Antithrombotic Therapy by the End of Hospital Day Two
- STK-06 - Discharged on Statin Medication
- STK-08 - Stroke Education
- STK-10 - Assessed for Rehabilitation
- VTE-1 - Venous Thromboembolism Prophylaxis
- VTE-2 - Intensive Care Unit Venous Thromboembolism Prophylaxis

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2017 IPPS Proposal - Validation

Current Validation Process Number of Hospitals	
Chart-Abstracted Random	400
Chart-Abstracted Targeted	200
Total	600

Proposed Validation Process Number of Hospitals	
Chart-Abstracted Random	400
Chart-Abstracted Targeted	200
eCQM: random	200
Total	800

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Enhanced Oversight and Accountability

- ONC expands role of oversight
- Clinicians required to give access to their EHR for “field inspection”
- Clinicians must attest to cooperating with ONC surveillance and oversight activities
- No restriction of data sharing and interoperability

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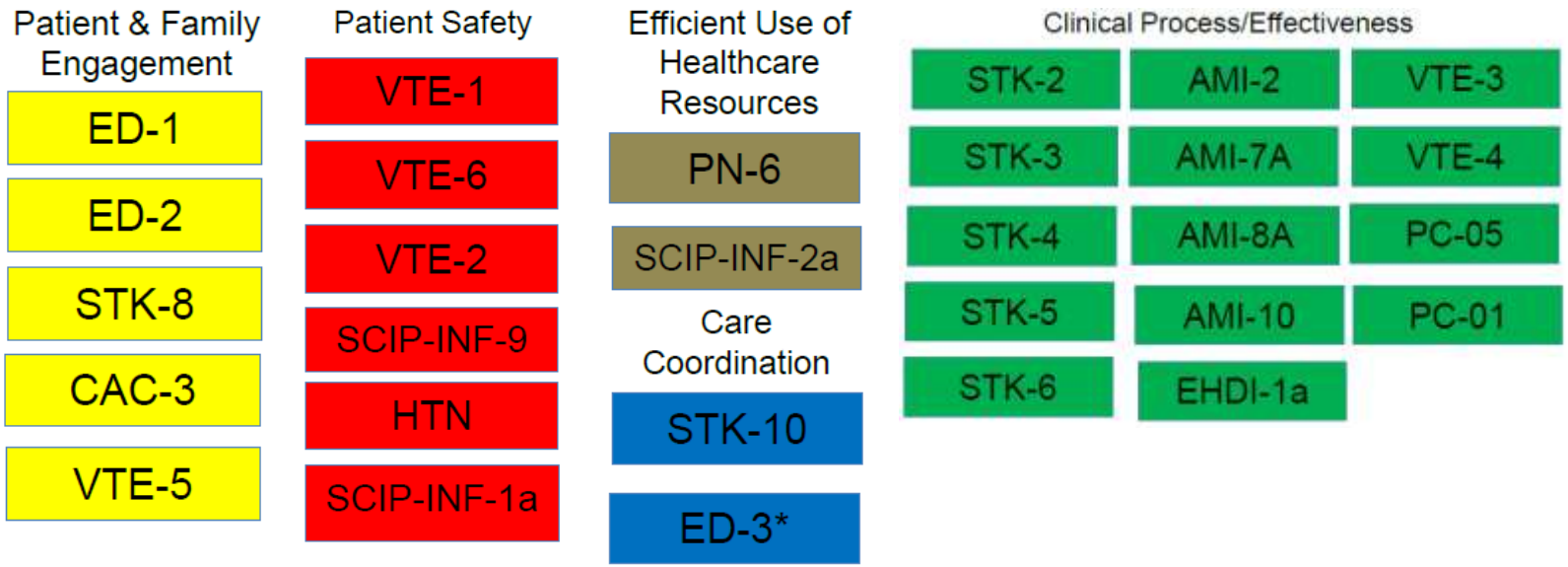
Meeting Requirements of Multiple Programs

IQR, MU, ORYX

Hospital Quality Measures

- Meaningful Use (MU)
- Inpatient Quality Reporting (IQR)
- Joint Commission (ORYX)



* Excluded from IQR and ORYX

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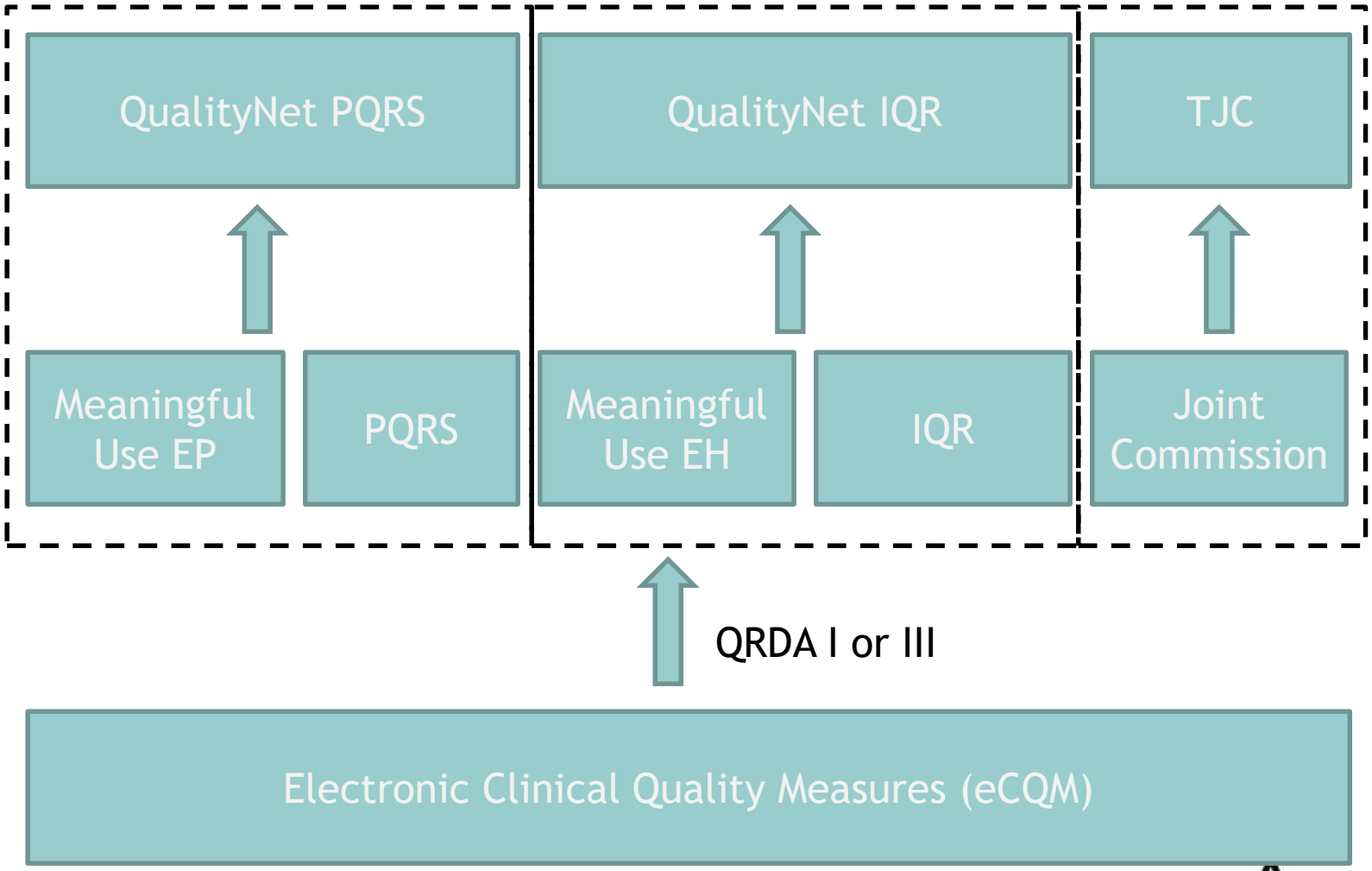
		✓ 4	✓ 4	✓ 6	✓ 8
Measure	**Description**	**MU EH**	**IQR**	**ORYX-eCQM**	**ABSTRACTION**
AMI-1	Aspirin at Arrival				
AMI-2	Aspirin at Discharge				
AMI - 7A	Fibrinolytic Therapy received within 30 minutes of Hospital Arrival			●	
AMI - 8A	Primary PCI Received Within 90 Minutes of Hospital Arrival				
AMI-10	Statin at Discharge				
ED-1	ED Arrival to Departure for Admitted Patients	●	●	●	●
ED-2	ED Admit Decision to Departure for Admitted Patients	●	●	●	●
ED-3	Median Time ED Arrival to ED Departure for discharged patients				
STK-1	Venous Thromboembolism (VTE) Prophylaxis				
STK-2	Discharge on Antithrombotic Therapy				
STK-3	Anticoagulation therapy for Atrial Fibrillation/Flutter				
STK-4	Thrombolytic Therapy	●	●	●	●
STK-5	Antithrombotic Therapy by end of Hospital Day 2	●	●	●	
STK-6	Discharged On Statin Medication				
STK-8	Stroke Education				
STK-10	Assessed forRrehabilitation				
VTE-1	Venous Thromboembolism Prophylaxis				
VTE-2	Intensive Care Venous Thromboembolism Prophylaxis			●	
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy			●	
VTE-4	Unfractionated Heparin				
VTE-5	Venous Thromboembolism Discharge Instructions				●
VTE-6	Incidence Of Potentially - Preventable Venous Thromboembolism				●

eCQM Reporting Submission



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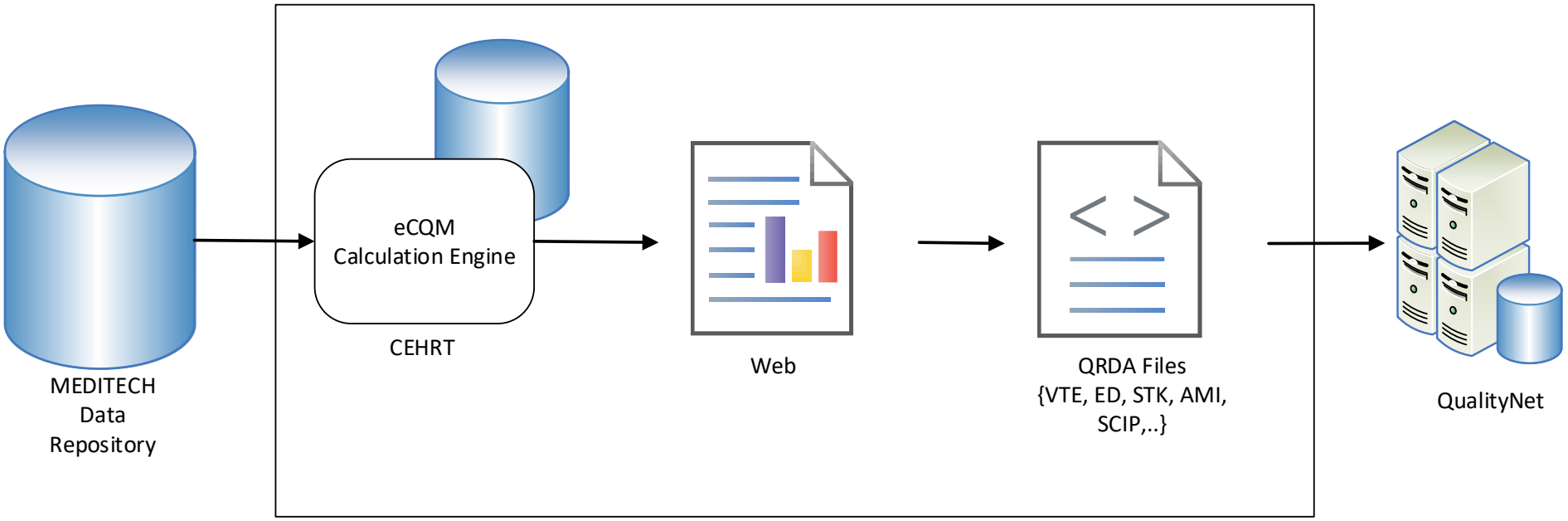
eCQM Reporting Diagram



Quality Measure Data Flow

eCQM Reporting Standards

- Introduction of universal identifier
  - Example: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
    - NQF# = 0373 (VTE-3)
    - eMeasure ID = CMS-73

- How do standardized nomenclature based code system work?
  - Using Quality Data Model (QDM) with HL7 QRDA (Quality Reporting Document Architecture)

- eCQM Library Specifications Published Annually
  - VTE-3 Example

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eMeasure Title	**Venous Thromboembolism Prophylaxis**		
eMeasure Identifier (Measure Authoring Tool)	108	**eMeasure Version number**	4.0.000
NQF Number	0371	**GUID**	38b0b5ec-0f63-466f-8fe3-2cd20ddd1622
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	The Joint Commission		
Measure Developer	The Joint Commission		
Endorsed By	National Quality Forum		
Description	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.		
Copyright	Measure specifications are in the Public Domain LOINC(R) is a registered trademark of the Regenstrief Institute. This material contains SNOMED Clinical Terms (R) (SNOMED CT[C]) copyright 2004-2014 International Health Terminology Standards Development Organization. All rights reserved.		
Disclaimer	These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The measures and specifications are provided without warranty		
Measure Scoring	Proportion		
Measure Type	Process		
Measure Item Count	Encounter, Performed: Encounter Inpatient		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Hospitalized patients at high-risk for VTE may develop an asymptomatic deep vein thrombosis (DVT), and die from pulmonary embolism (PE) even before the diagnosis is suspected. The majority of fatal events occur as sudden or abrupt death, underscoring the importance of prevention as the most critical action step for reducing death from PE (Geerts, et al, 2008). The estimated annual incidence of deep-vein thrombosis (DVT) and pulmonary embolism (PE), known collectively as venous thromboembolism (VTE), is approximately 900,000 (Geerts, et al, 2008). Approximately two-thirds of cases of DVT or PE are associated with recent hospitalization. This is consistent with the 2001 report by The Agency for Healthcare Research and Quality (AHRQ). AHRQ indicates that "the appropriate application of effective preventive measures in hospitals has major potential for improving patient safety by reducing the incidence of venous thromboembolism" (Shojania, 2001). Despite its proven effectiveness, rates of appropriate thromboprophylaxis remain low in both medical and surgical patients. A recent analysis from the ENDORSE survey, which evaluated prophylaxis rates in 17,084 major surgery patients, found that more than one third of patients at risk for VTE (38%) did not receive prophylaxis and that rates varied by surgery type (Cohen, et al., 2008). In a review of evidence-based patient safety practices, the Agency for Healthcare Research and Quality defined thromboprophylaxis against VTE as the "number one patient safety practice" for hospitalized patients (Shojania, 2001). Updated "safe practices" published by the National Quality Forum (NQF) recommend routine evaluation of hospitalized patients for risk of VTE and use of appropriate prophylaxis (National Quality Forum. National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism, 2006). As noted by the ACCP, a vast number of randomized clinical trials provide irrefutable evidence that thromboprophylaxis reduces VTE events, and there are studies that have also shown that fatal PE is prevented by thromboprophylaxis (Geerts, et al. 2008).		

Reconcile and Validate eCQMs

VTE-3 Reporting Example

eMeasure Identifier: CMS-73

Description:
This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.

Data criteria (QDM Data Elements):
"Medication, Administered: Warfarin" using "Warfarin RXNORM Value Set (2.16.840.1.113883.3.117.1.7.1.232)"
"Medication, Discharge not done: Medical Reason" using "Medical Reason SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.473)"
"Medication, Discharge not done: Patient Refusal" using "Patient Refusal SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.93)"
"Medication, Discharge: Parenteral Anticoagulant" using "Parenteral Anticoagulant RXNORM Value Set (2.16.840.1.113883.3.117.1.7.1.266)"
"Medication, Discharge: Parenteral anticoagulant ingredient specific" using "Parenteral anticoagulant ingredient specific RXNORM Value Set (2.16.840.1.113762.1.4.1021.4)"
"Medication, Order not done: Medical Reason" using "Medical Reason SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.473)"
"Medication, Order not done: Patient Refusal" using "Patient Refusal SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.93)"

VTE-3 Reporting Example

eMeasure Identifier: CMS108

Data criteria (QDM Data Elements):
"Medication, Administered: Warfarin" using "Warfarin RxNorm Value Set (**2.16.840.1.113883.3.117.1.7.1.232**)"

Value Set Table:

ValueSetName	ValueSetOID	Code	Description	Code System
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855288	Warfarin Sodium 1 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855296	Warfarin Sodium 10 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855302	Warfarin Sodium 2 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855308	Warfarin Sodium 2 MG/ML Injectable Solution	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855312	Warfarin Sodium 2.5 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855318	Warfarin Sodium 3 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855324	Warfarin Sodium 4 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855332	Warfarin Sodium 5 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855338	Warfarin Sodium 6 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855344	Warfarin Sodium 7.5 MG Oral Tablet	RXNORM

This shows a value set for a class of medications (Warfarin)

VTE-3 Reporting Example

eMeasure Identifier: CMS108

Data criteria (QDM Data Elements):
"Medication, Administered: Warfarin" using "Warfarin RxNorm Value Set (**2.16.840.1.113883.3.117.1.7.1.232**)“

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Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855308	Warfarin Sodium 2 MG/ML Injectable Solution	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855312	Warfarin Sodium 2.5 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855318	Warfarin Sodium 3 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855324	Warfarin Sodium 4 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855332	Warfarin Sodium 5 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855338	Warfarin Sodium 6 MG Oral Tablet	RXNORM
Warfarin	2.16.840.1.113883.3.117.1.7.1.232	855344	Warfarin Sodium 7.5 MG Oral Tablet	RXNORM

VisitID	Code	CodeSystem	ValueSetOID	DateTime	Value	LowValue	ValueSetName
642342413A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.201	2012-04-01 17:00:00.000	ADMIN	2012-04-01 17:00:00.000	Warfarin
642342491A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.201	2012-04-02 00:08:28.000	ADMIN	2012-04-02 00:08:28.000	Warfarin
642342353A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.201	2012-04-01 14:00:00.000	ADMIN	2012-04-01 14:00:00.000	Warfarin
642342413A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-01 17:00:00.000	ADMIN	2012-04-01 17:00:00.000	Warfarin
642342491A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-02 00:08:28.000	ADMIN	2012-04-02 00:08:28.000	Warfarin
642342353A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-01 14:00:00.000	ADMIN	2012-04-01 14:00:00.000	Warfarin

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VTE-3 Reporting Example

eMeasure Identifier: CMS108

Data criteria (QDM Data Elements):
"Medication, Administered: Warfarin" using "Warfarin RXNORM Value Set **(2.16.840.1.113883.3.117.1.7.1.232)**"
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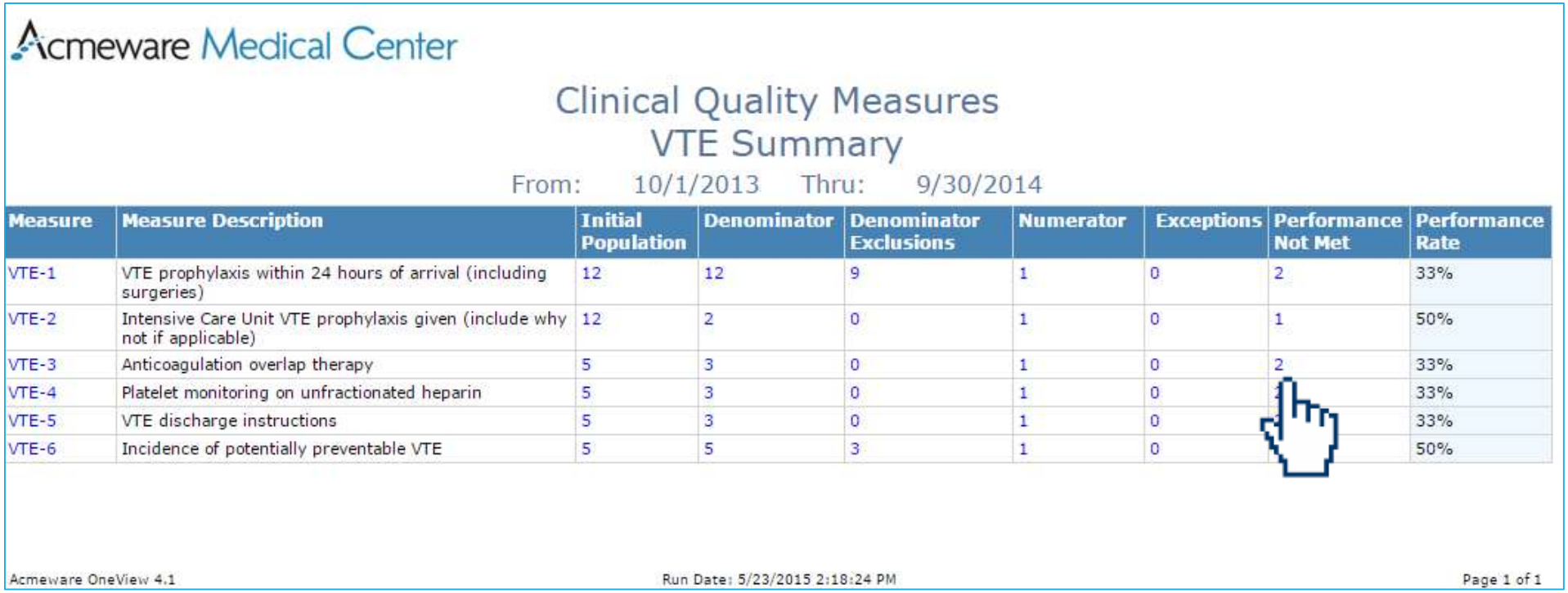
642342491A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.201	2012-04-02 00:08:28.000	ADMIN	2012-04-02 00:08:28.000	Warfarin
642342353A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.201	2012-04-01 14:00:00.000	ADMIN	2012-04-01 14:00:00.000	Warfarin
642342413A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-01 17:00:00.000	ADMIN	2012-04-01 17:00:00.000	Warfarin
642342491A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-02 00:08:28.000	ADMIN	2012-04-02 00:08:28.000	Warfarin
642342353A	855332	RXNORM	2.16.840.1.113883.3.117.1.7.1.232	2012-04-01 14:00:00.000	ADMIN	2012-04-01 14:00:00.000	Warfarin

VTE-3 Reporting Example



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Clinical Quality Measures
VTE Summary

From: 10/1/2013 Thru: 9/30/2014

Measure	Measure Description	Initial Population	Denominator	Denominator Exclusions	Numerator	Exceptions	Performance Not Met	Performance Rate
VTE-1	VTE prophylaxis within 24 hours of arrival (including surgeries)	12	12	9	1	0	2	33%
VTE-2	Intensive Care Unit VTE prophylaxis given (include why not if applicable)	12	2	0	1	0	1	50%
VTE-3	Anticoagulation overlap therapy	5	3	0	1	0	2	33%
VTE-4	Platelet monitoring on unfractionated heparin	5	3	0	1	0	2	33%
VTE-5	VTE discharge instructions	5	3	0	1	0	2	33%
VTE-6	Incidence of potentially preventable VTE	5	5	3	1	0	1	50%

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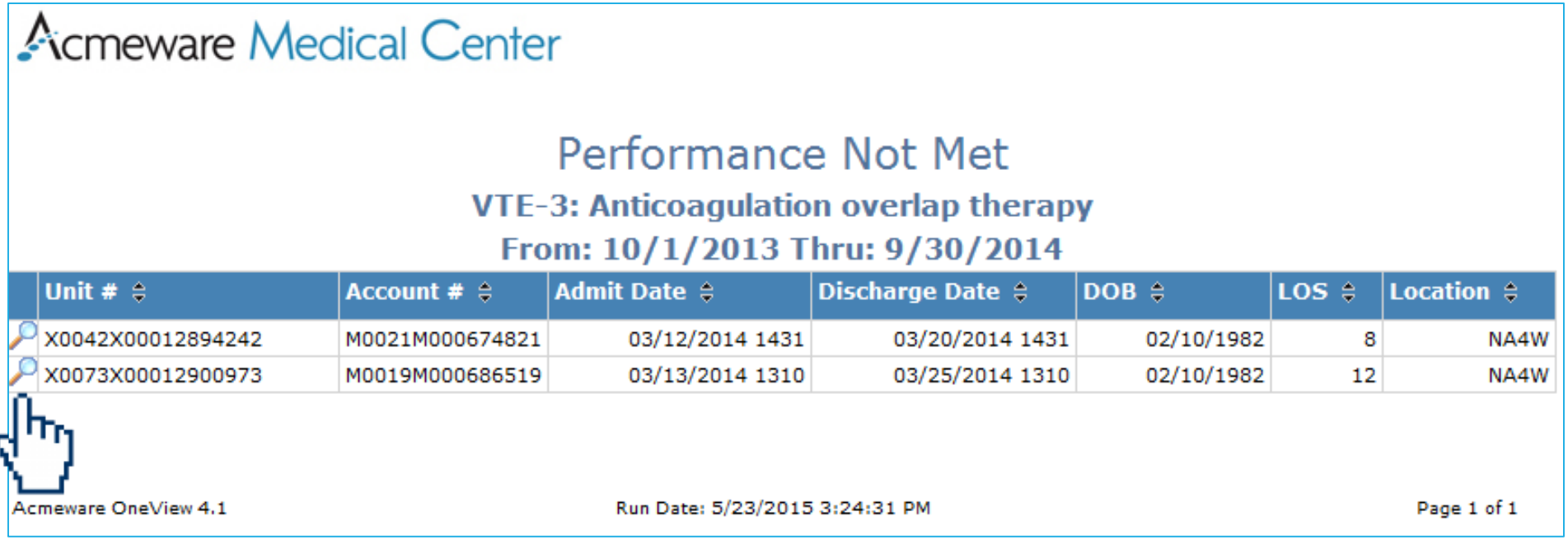
VTE-3 Reporting Example



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VTE-3 Reporting Example

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Measure Summary Report

Patient: RUTH ZTESTELL
Account: ACT417174
Unit #: UNT05948
Measure: VTE-3
Description: Anticoagulation overlap therapy

Expand All | Collapse All

	✓	⊞ **Population**
	✓	⊟ **Denominator**
OR	✓	⊟ VTE Diagnostic Test (result: 'VTE Confirmed') and Warfarin with the following criteria:
AND	✓	⊟ VTE Diagnostic Test (result: 'VTE Confirmed') during or <= 2 days before Inpatient Encounter
OR	✗	VTE Diagnostic Test (result: 'VTE Confirmed') during Inpatient Encounter
OR	✓	VTE Diagnostic Test (result: 'VTE Confirmed') <= 2 days before Inpatient Encounter
AND	✓	⊟ Medication, Administered: Warfarin during or <= 2 days before Inpatient Encounter
OR	✓	Medication, Administered: Warfarin during Inpatient Encounter
OR	✓	Medication, Administered: Warfarin <= 2 days before Inpatient Encounter
OR	✓	⊟ If had ED Visit, diagnosis active in ED, otherwise diagnosis active as Inpatient
AND	✓	⊟ ED Visit, diagnosis active during ED Visit
AND	✓	⊟ Inpatient Encounter: admission datetime <= 1 hour(s) starts after ED Visit (departure datetime)
AND	✓	Emergency Department Visit
AND	✓	Inpatient Encounter
AND	✓	admission datetime <= 1 hour(s) starts after after ED Visit (departure datetime)
AND	✓	⊟ VTE Diagnostic Test (result: 'VTE Confirmed') and Medication, Administered: Warfarin with the following criteria:
AND	✓	⊟ VTE Diagnostic Test (result: 'VTE Confirmed') during or <= 2 days before ED Visit or during Inpatient Encounter
OR	✓	VTE Diagnostic Test (result: 'VTE Confirmed') during ED Visit
OR	✓	VTE Diagnostic Test (result: 'VTE Confirmed') <= 2 days before ED Visit
OR	✗	VTE Diagnostic Test (result: 'VTE Confirmed') during Inpatient Encounter
AND	✓	⊟ Medication, Administered: Warfarin during or <= 2 days before ED Visit
OR	✗	Medication, Administered: Warfarin during ED Visit
OR	✓	Medication, Administered: Warfarin <= 2 days before ED Visit
	✗	⊞ **Exclusion**
	✗	⊞ **Numerator**
	✗	**Exception**

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VTE-3 Reporting Example

HL7 QRDA (XML File) Snippet for Patient Visit that meets NQF#: 0371

```
<entry>
  <act classCode="ACT" moodCode="EVN" >
    <!-- Medication, Administered template -->
    <templateId root="2.16.840.1.113883.10.20.24.3.42"/>
    <id root="1.3.6.1.4.1.115" extension="51df41e9b490d176750000bc"/>
    <code code="416118004" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Administration"/>
    <statusCode code="completed"/>
    <effectiveTime xsi:type="IVL_TS">
      <low value='20120401170000'/>
      <high value='20120401170000'/>
    </effectiveTime>
    <entryRelationship typeCode="COMP">
      <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- Medication Activity (consolidation) template -->
        <templateId root="2.16.840.1.113883.10.20.22.4.16"/>
        <id root="e2c2bd70-ecb9-0130-a501-22000aa43ef1"/>
        <text>Medication, Administered: Warfarin (Code List: 2.16.840.1.113883.3.117.1.7.1.232)</text>
        <statusCode code="completed"/>
        <effectiveTime xsi:type="IVL_TS">
          <low value='20120401170000'/>
          <high value='20120401170000'/>
        </effectiveTime>
        <consumable>
          <manufacturedProduct classCode="MANU">
            <!-- Medication Information (consolidation) template -->
            <templateId root="2.16.840.1.113883.10.20.22.4.23"/>
            <id root="e2c2da50-ecb9-0130-a501-22000aa43ef1"/>
            <manufacturedMaterial>
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                <originalText>Medication, Administered: Warfarin (Code List: 2.16.840.1.113883.3.117.1.7.1.232)</originalText>
              </code>
            </manufacturedMaterial>
          </manufacturedProduct>
        </consumable>
      </substanceAdministration>
    </entryRelationship>
  </act>
</entry>
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Challenges

- Disparate Systems
- Difficult to assess performance across settings
- Creation of Clinical Alerts
- Coding occurs post discharge
- Understanding workflow required by eCQMs
- Transition from free text and customized reporting

Discussion, Q&A

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