CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) QUALITY PROGRAMS
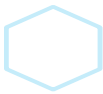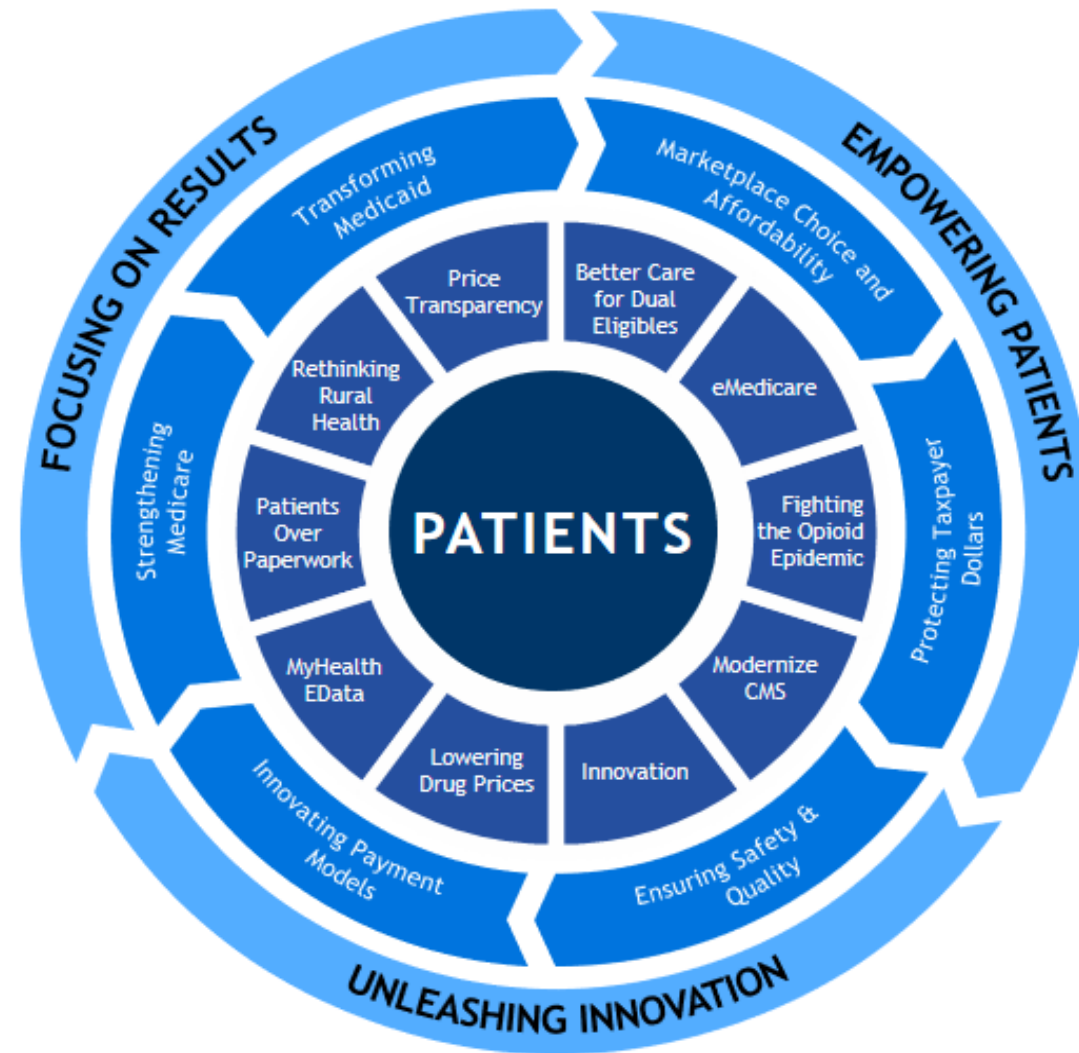
Michigan HIMSS
October 2019

CMS LEVERS FOR CHANGE

- Incentives and Penalties
- Collaborative Improvement Initiatives
- Payment Reform
- Public Reporting/Transparency
- Regulatory Requirements
- Empowering Patients (Rise of Consumerism)

VALUE BASED PROGRAMS

- Hospital Inpatient Quality Reporting Program
- Hospital Value Based Purchasing Program and Stars Program
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Centers Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Program
- ESRD Quality Incentive Program
- Hospital Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program
- Merit Based Incentive Payment System (MIPS)
- Prospective Payment System for Exempt Cancer Hospital Quality Program
- Skilled Nursing Facility Value Based Program
- Home Health Quality Reporting Program
- Hospice Quality Reporting Program
- Inpatient Rehabilitation Facility Quality program
- Long Term Care Hospital Quality Reporting Program
- Promoting Interoperability – Hospital Program and Eligible Provider Program
- Marketplace – QRS Measure Set and Stars Program
- CM – Purchaser MA Stars
- Medicaid – Dashboards
- CMMI – Multiple Value Based Models

Meaningful Measures Framework

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Affordable

Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:
- Healthcare-associated Infections
- Preventable Healthcare Harm

Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Functional Outcomes

FOCUS OF MEANINGFUL MEASURES

- Refine list of measures to parsimonious set of high impact measures
- Reduce/eliminate less impactful measures – such as clinical evidence changed, duplicative measures
- Identify gap areas for development
- Accelerate conversion to measures solely based on electronic data sources
- Key strategic areas:
  - Maternal Mortality and Morbidity
  - Opioids
  - Sepsis
  - Safety
  - Nursing Home Safety
  - Population Health
  - Patient Reported Outcomes
  - Cost Measures

eCQM STRATEGY RECOMMENDATIONS

ALIGNMENT
- eCQM reporting requirements across CMS program care settings
- eCQM specifications, value sets, and data collection

COMMUNICATION, EDUCATION, AND OUTREACH
- Coordinated education and outreach campaigns to learn from stakeholders and share CMS program information
- Measure-level webinars
- Clear eCQM guidance, plain language, and improved website usability

VALUE
- Quality dashboard best practice collaboration between providers and CMS
- Data element definitions

EHR CERTIFICATION PROCESS
- eCQM certification aligned with CMS reporting requirements

DEVELOPMENT PROCESS
- Collaborative Measure Development Workspace
- Data element repository
- Clinically feasible workflow for data capture
- Feasibility testing for new data elements

eCQM Strategy Goals
- Reduce Burden
- Increase Value
- Increase Stakeholder Involvement

IMPLEMENTATION AND REPORTING PROCESSES
- Clear eCQM specifications, tools, and resources
- Feasible data elements
- Submission of data elements and eCQMs with FHIR and APIs
- Use of eCQM standards to support interoperability
- Consolidated pre-submission validation testing tools
- eCQM attribution research and pilots

06/2018

TRANSPARENCY

- Transparency important so that patients have access to information to make best healthcare choices. Transparency has also engaged organizations in more quality improvement.
- Star ratings and transparency for patients
  - My Health e-data for patients
  - Nursing Home Compare
  - Hospital Compare
  - Physician Compare
- Price Transparency
- Quality Data Strategy
  - More rapid feedback to clinicians
  - API development for sharing quality data
  - Sharing data more broadly for research

ALIGNMENT

- One source of burden and confusion is that quality measures are not always aligned across all payers.
- CMS is engaged in multiple initiatives to promote alignment:
  - CQMC – Core Quality Measures Collaborative – between AHIP (Americas Health Insurance Plans), NQF and CMS to determine core ambulatory measures which can be agreed upon for ALL payers
  - Alignment efforts across CMS – Medicare FFS (traditional measures), Medicare Advantage, Medicaid, CMMI
  - Alignment efforts with VA and DOD per Presidential Executive Order
  - Alignment and efforts to review the CMS Measure Inventory (CMIT) to eliminate redundancies and measures with changed clinical evidence or measures that are topped out
  - Alignment efforts with QCDR (qualified clinical registries) to promote alignment and sharing of measures

DO WE NEED SOCIAL RISK ADJUSTMENT? HOW?

- Dual Eligible Status

- Specific Risk Adjustment Factors

  o REL

  o Safety Net/DSH payments

  o Transportation

  o Food Availability

  o Literacy/Education

  o Community Characteristics ("stressed cities")

ADVANCING INTEROPERABILITY

Key Priority to Improve Quality, Safety and Value
and Patient Engagement

A lack of seamless data exchange in healthcare…

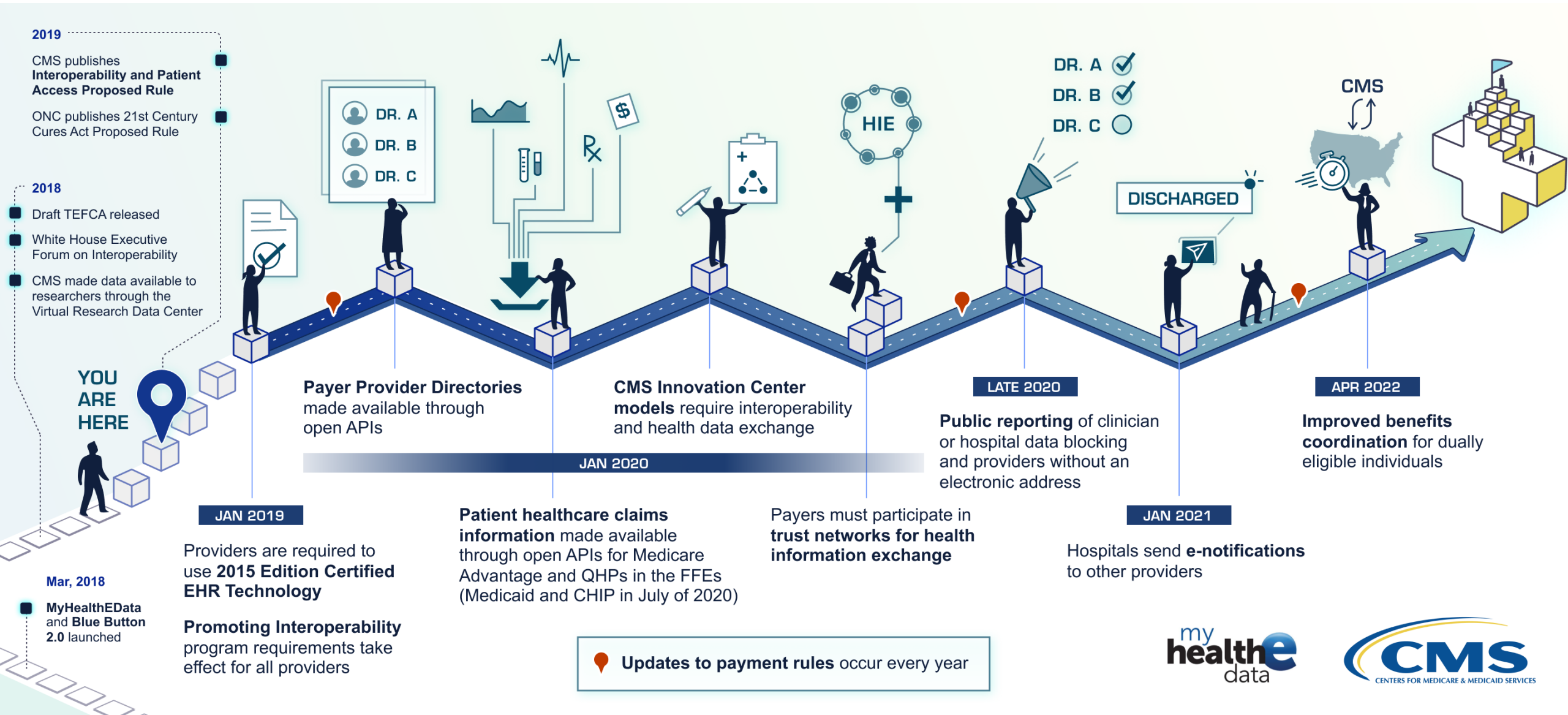PATIENTS

PROVIDERS

PAYERS

leads to disconnected care, worse health outcomes, and higher costs.

Interoperable healthcare data exchange…

PATIENTS

TAKE OWNERSHIP OVER THEIR HEALTH DATA

CONFIDENTLY PROVIDE THE BEST CARE TO PATIENTS

PROVIDERS

PAYERS

PROVIDE MORE EFFICIENT CARE COORDINATION AND COVERAGE

enables coordinated care, improved health outcomes, and reduced cost.

How might we get there?

2019

CMS publishes **Interoperability and Patient Access Proposed Rule**

ONC publishes 21st Century Cures Act Proposed Rule

2018

Draft TEFCA released

White House Executive Forum on Interoperability

CMS made data available to researchers through the Virtual Research Data Center

YOU ARE HERE

Mar, 2018

MyHealthEData and **Blue Button 2.0** launched

JAN 2019

Providers are required to use **2015 Edition Certified EHR Technology**

Promoting Interoperability program requirements take effect for all providers

Payer Provider Directories made available through open APIs

Patient healthcare claims information made available through open APIs for Medicare Advantage and QHPs in the FFEs (Medicaid and CHIP in July of 2020)

JAN 2020

CMS Innovation Center models require interoperability and health data exchange

Payers must participate in **trust networks for health information exchange**

LATE 2020

Public reporting of clinician or hospital data blocking and providers without an electronic address

JAN 2021

Hospitals send **e-notifications** to other providers

APR 2022

Improved benefits coordination for dually eligible individuals

DISCHARGED

DR. A
DR. B
DR. C

HIE

CMS

📍 **Updates to payment rules** occur every year

my health**e** data

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

The proposed rule would lay the foundation for healthcare interoperability.

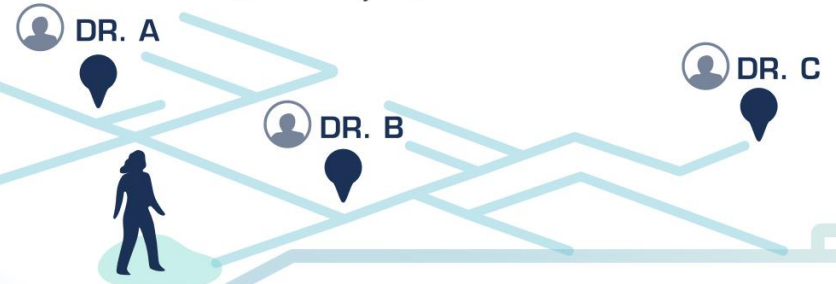# How might these proposals impact me?

1 I can **easily access my health claims data**, including information about my treatment history and prescriptions.

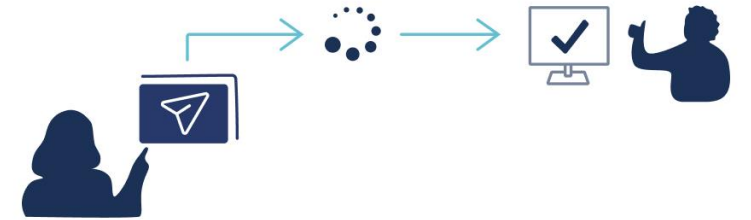**2** I can easily find an **up-to-date list of providers** in my network.

DR. A

DR. B

DR. C

6 **Better communication** between my providers means I don't fall through the cracks.

SNF

DISCHARGED

3 I can **bring my data with me** when I switch plans or providers.

PATIENTS

5 I know which providers are sharing data, and **reports about data blocking** help me choose where to get care.

DR. A ✓
DR. B ✓
DR. C ◌

4 I know my coverage benefits are being **coordinated**.

CMS
☑ ☑   ☑ ☑

The proposals would help empower me to take ownership over my health data.

How might these proposals impact me?

1 With **better access to patient data**, I can provide more informed treatment recommendations and help my patients make better care decisions.

2 I know how to **contact other providers** my patient is seeing so we can share information and provide coordinated care.

DR. B

DR. C

DR. A

PROVIDERS
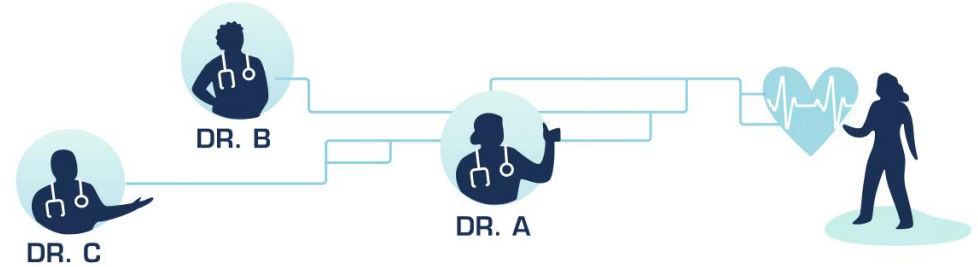
4 As a participant in **alternative payment models**, I can showcase my commitment to health care interoperability and standards-based data exchange.
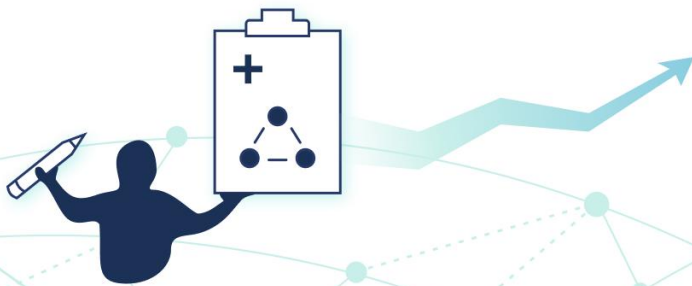
3 **E-notifications** that my patients are admitted or discharged keep me in the loop.

SNF

PT. DISCHARGED

The proposals would help me to confidently provide better care to patients.

How might these proposals impact me?

1 **Sharing health information** with patients better engages them and strengthens our relationship.
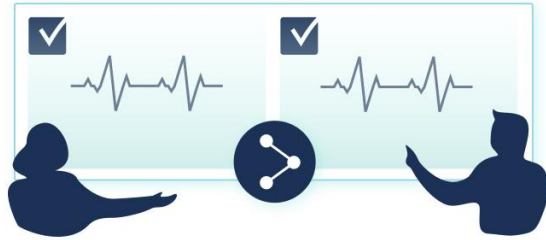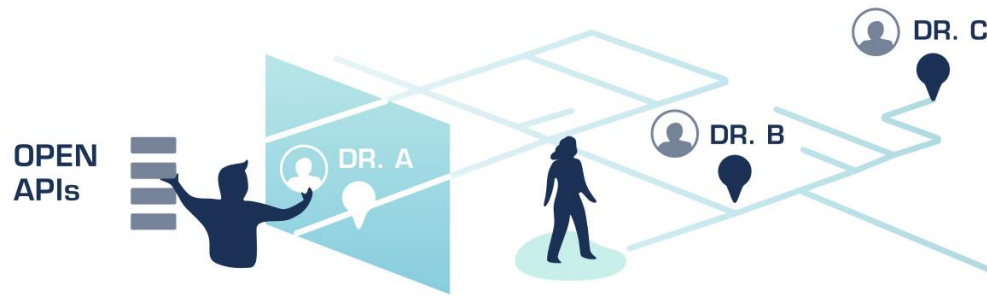
2 **Historical claims data** helps patients understand their healthcare expenses.
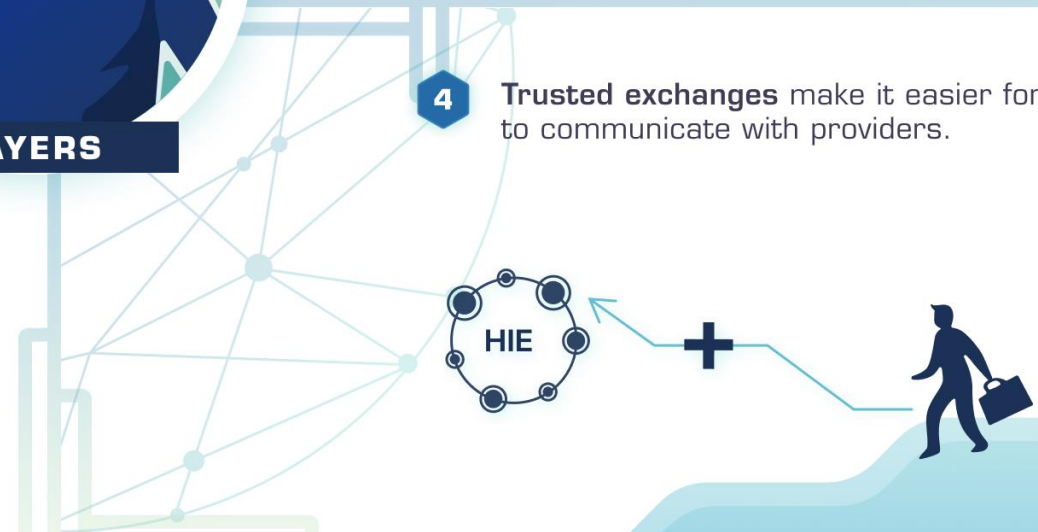
3 **Care Coordination** with other payers helps me provide coverage to get my patients the best outcomes.

PAYERS

5 **Offering a provider directory through an API** helps my patients find the doctors they need.

4 **Trusted exchanges** make it easier for me to communicate with providers.
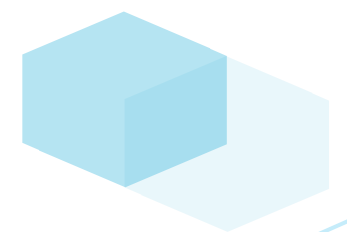
DR. C

DR. B

OPEN APIs

DR. A

HIE

The proposals would increase my ability to provide more efficient and coordinated coverage.

PROPOSED RULES

ONC and CMS 2019

Caveat: Cannot speak to final rule

CMS Interoperability & Patient Access Proposed Rule

- Along with ONC 21st Century Cures Act, the CMS Interoperability Proposed Rule signals the commitment to improve access to, and the quality of, information that Americans need to make informed health care decisions
- Includes data about health care prices and outcomes
- Minimizes reporting burdens on plans and providers
- Currently technology may be available but data are not moving: Patients are not empowered with their data; providers do not have data when they need it most (at the point of caring for patients)
- Reaches all CMS payers: MA, Medicaid and CHIP FFS, Medicaid and CHIP Managed Care, Qualified Health Plans, Medicare FFS

KEY PROPOSALS for Payers

- Patient Access API – all CMS regulated payers to build and maintain a secure, standards-based (FHIR) API that would allow patients to access their health information. Includes claims, clinical data and lab results where available.

- Provider Directories API – make provider directory information available via standards-based (FHIR) API

- Payer to Payer Exchange – Coordinate care for patients by exchanging certain patient data at enrollee's request – USCDI (US Core Data for Interoperability) as proposed by ONC. Enrollee can request data up to 5 years after disenrollment

- Trust Networks – participate in a trust network meeting specified criteria to improve interoperability

- Dual Eligible – update frequency with which states are required to exchange certain data

KEY PROPOSALS for Providers

- Public Reporting of Information Blocking – publicly report data related to information blocking attestations on appropriate CMS websites

- Public Reporting of NPESS Digital Contact Information – Improved capacity of National Plan and Provider Enumeration System to capture one or more pieces of digital contact information.

- CoPs for Hospitals and CAHs – revise Conditions of Participation (CoP) to require hospitals to send electronic patient event notifications of admission, discharge, transfer (ADT) to another health care facility or to another community provider

Requests for Information (RFI)

- Incorporating Interoperability into CMMI Models

- Patient Matching

- Interoperability in Post Acute Care Settings

FHIR

- CMS and ONC have collaboratively identified the API standard for interoperability known as FHIR – Fast Healthcare Interoperability Resources, to enable collaboration and sharing of information

- FHIR based API's in testing through DaVinci project to test transmission of information from payer to provider regarding prior authorization

- FHIR based standards for electronic quality measures being tested with 3 measures: VTE (venous thromboembolism), hypertension and immunization

OTHER CONSIDERATIONS FOR LEVERAGING HEALTH INFORMATION TECHNOLOGY

Data Driven Decision Making

- There is an immense amount of data/information ... is there wisdom or ability for action?

- Role of advanced data analytics, "big data" use, Advanced Artificial Intelligence and Machine Learning

- Dartmouth Atlas provides example of trending analysis

- Many analytics vendors have capabilities to examine outcomes, provide feedback reports, identify outliers

- How should "big data" best be leveraged?

Patient Reported Outcome Measures (PROM)

- Patient voice is ESSENTIAL in quality program

- Current PROM are not easy to use, often require additional FTE staffing to call patients, are not integrated into current electronic records (providers need to log into another system to view and use)

- How best to outreach to consumers? What about the "digital divide"?

- Currently there are some PROM in MIPS; none in hospital measures except the customer experience scores

- Future direction: include more PROM, potential for different ways to do this

Engaging Patients Thru Transparency

- My Health e-Data
  - One of 16 key CMS priorities
  - Provides Medicare beneficiaries information on their claims and some clinical data
- Blue Button 2.0
- Compare sites
- Informed consumers make better care choices

Issues to Address

- Patient Matching

- HIPAA and sharing of information

- Same Standards, same data elements

- Verification of information

- Data Security

Technical Assistance

Quality Payment PROGRAM

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:
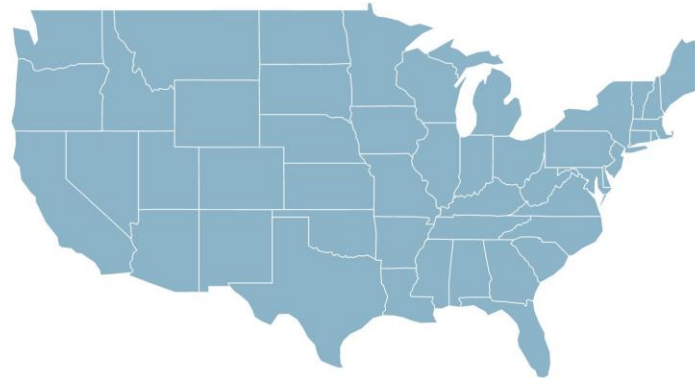
Small & Solo Practices
Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or assistance getting connected, contact QPPSURS@IMPAQINT.com.

Technical Support
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website: qpp.cms.gov**
  Serves as a starting point for information on the Quality Payment Program.
- **Quality Payment Program Sevice Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov
- **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Questions

Michelle.Schreiber@cms.hhs.gov