Digital Quality Measure Strategy: Policy Implications

NAACOS Spring Conference 2024

MSSP Quality Req's

2021 & 2022 Medicare PFS Rules made significant changes to the way ACOs are evaluated on quality for purposes of MSSP – creating the new APM Performance Pathway (APP) quality structure

APP was designed to align quality measurement and scoring in MSSP with the Merit-Based Incentive Payment System (MIPS)

This will require ACOs to move to electronic clinical quality measure (eCQM), MIPS CQM or Medicare CQM reporting for PY 2025 (data reported in early 2026)

Future of Measurement

- **CMS is moving toward digital quality measurement (dQMs)**
  - Meaningful Measures 2.0 initiative emphasizes dQMs – which originate from health information captured and transmitted electronically via interoperable systems
- CMS digital strategy focuses on:
  - Using FHIR-based standards to exchange clinical information through APIs, allowing clinicians to digitally submit quality information one time which can be used in many ways
  - Accelerating the transition to fully electronic measures
  - Working across CMS to use artificial intelligence to identify quality problems and intervene before harm comes to patients
  - Developing more APIs for quality measure data submission and interoperability

CMS Goal: Improve quality measure efficiency by transitioning to digital measures and using advanced data analytics

Challenges

Key challenges for ACOs moving to digital measures:

- Data aggregation across disparate EHRs
- Patient de-duplication
- Costs (internal and vendor support)
- Impact on quality scores due to all payer evaluation
- Impact on ACOs with high proportions of specialists

CMS is moving ACOs to eCQMs (QRDA I/III) or MIPS CQMs/Medicare CQMs– at the same time CMS and ONC are focused on FHIR for the future

eCQMs

- **eCQMs = report data directly from Certified EHR Technology (CEHRT)**
  - All originating data must come from CEHRT - no abstraction, manual manipulation or supplementation
  - 75% data completeness req., but CMS assumes 100% data completeness
- Aggregate data across ACO participant TINs and do patient matching/de-duplication before submitting aggregate level data to CMS, **reporting on all patients/all payer data**
  - Collect QRDA I w/ patient level information
- Benchmarks are lower compared to MIPS CQM (recognizing the difficulty involved)

MIPS CQMs

- **MIPS CQMs = more flexibility in reporting**
  - Flat files, registry, EHR; abstraction permitted
  - 75% data completeness
- Aggregate data across ACO participant TINs and do patient matching/de-duplication before submitting aggregate level data to CMS, **reporting on all patients/all payer data**
- Benchmarks are higher compared to eCQMs, b/c of the ability to supplement data beyond what is in discrete EHR fields

Medicare CQMs

- **Medicare CQMs – avail. for PY 2025 (report in 2026)**
  - CMS intends to be a time limited, transitional option (report MIPS CQM measures on a more limited patient pop)
  - Limits scoring challenges with the all-payer approach used in eCQM/MIPS CQM reporting (equity concerns, specialty provider concerns), but still requires data aggregation/de-duplication
- 75% data completeness requirement
- Benchmarks to be created using performance period data (new reporting type, no historic scores) and based only on ACOs reporting Medicare CQMs

Medicare CQMs

Medicare CQM Patient =

- Meets the criteria for a beneficiary to be assigned to an ACO; and
  - Had at least one claim w/ a DOS during the measurement period from an ACO professional who is a primary care physician or who has one of the specialty designations included at §425.402(c); or who is a PA, NP or CNS
- A Medicare FFS beneficiary who is voluntarily aligned to the ACO
- CMS Medicare CQM checklist resource & patient info shared in quarterly informational reports

Medicare CQMs

- **CMS will provide ACOs with a quarterly list of beneficiaries eligible for Medicare CQMs in the Quarterly Informational Report Packages**
  - List will be cumulative and updated quarterly to reflect the most recent quarter's data
  - 4th quarter list of beneficiaries will include encounters w DOS 1/1-12/31 of the performance year – delivered typically in Feb.
  - List will include age, diagnosis, encounter and exclusion flags (to extent info is avail through claims and administrative systems) – flags meant to assist and do not replace the need to evaluate patients for the denominator criteria

- **Medicare CQMs can be submitted by the ACO or a third-party intermediary**
  - Allows for use of multiple data sources (like MIPS CQMs) to compile numerator and denominator
  - CMS created identifiers that reflect the quality number followed by "SSP" which must be included in submission files (001SSP, 134SSP, 236SSP)

APP Measures - 2024

eCQM, MIPS CQM, Medicare CQM	Web Interface
Diabetes HbA1c Poor Control (>9%)	Diabetes HbA1c Poor Control (>9%)
Controlling High Blood Pressure	Controlling High Blood Pressure
Screening for Depression and Follow-up Plan	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CAHPS for MIPS Survey	Screening for Future Fall Risk
Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions	Influenza Immunization
	Tobacco Use: Screening and Cessation Intervention
	Colorectal Cancer Screening
	Breast Cancer Screening
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
	Depression Remission at 12 Months
	CAHPS for MIPS Survey
	Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions

*Measure specifications and benchmarks vary based on reporting method selected; shading indicates outcome/intermediate outcome measure

Weighing Options

- Numerous options available to report
- Investments required for all options
- Questions to consider:
  - What resources can you devote now, what resources will you need to invest in the near future as measurement continues to evolve

Policy Incentives to Report

- Incentives for eCQM/MIPS CQM reporting:
  - Extension of incentives in place for reporting eCQMs/MIPS CQMs through 2024
  - 10th percentile on one of the four outcome measures, 40th percentile on one of the remaining measures to meet Quality Performance Standard
  - Bonus opportunity for ACOs reporting eCQMs/MIPS CQMs and serving a large proportion of underserved communities (up to 10 pts)
- NAACOS is calling on CMS to strengthen incentives in place for ACOs reporting eCQMs/MIPS CQMs – pay-for-reporting, upfront funding and/or adjustments to financial benchmarks

NAACOS Advocacy

NAACOS advocacy calling on CMS to continue all reporting options until feasibility for eCQMs and dQMs have been tested

Get involved in advocacy efforts:

Quality Committee
Policy Committee
eCQM Implementation Group

Resources:

NAACOS quality webpage
New NAACOS Resources – reporting and scoring req's
QPP Resource Center

MaineHealth
Accountable Care
Organization

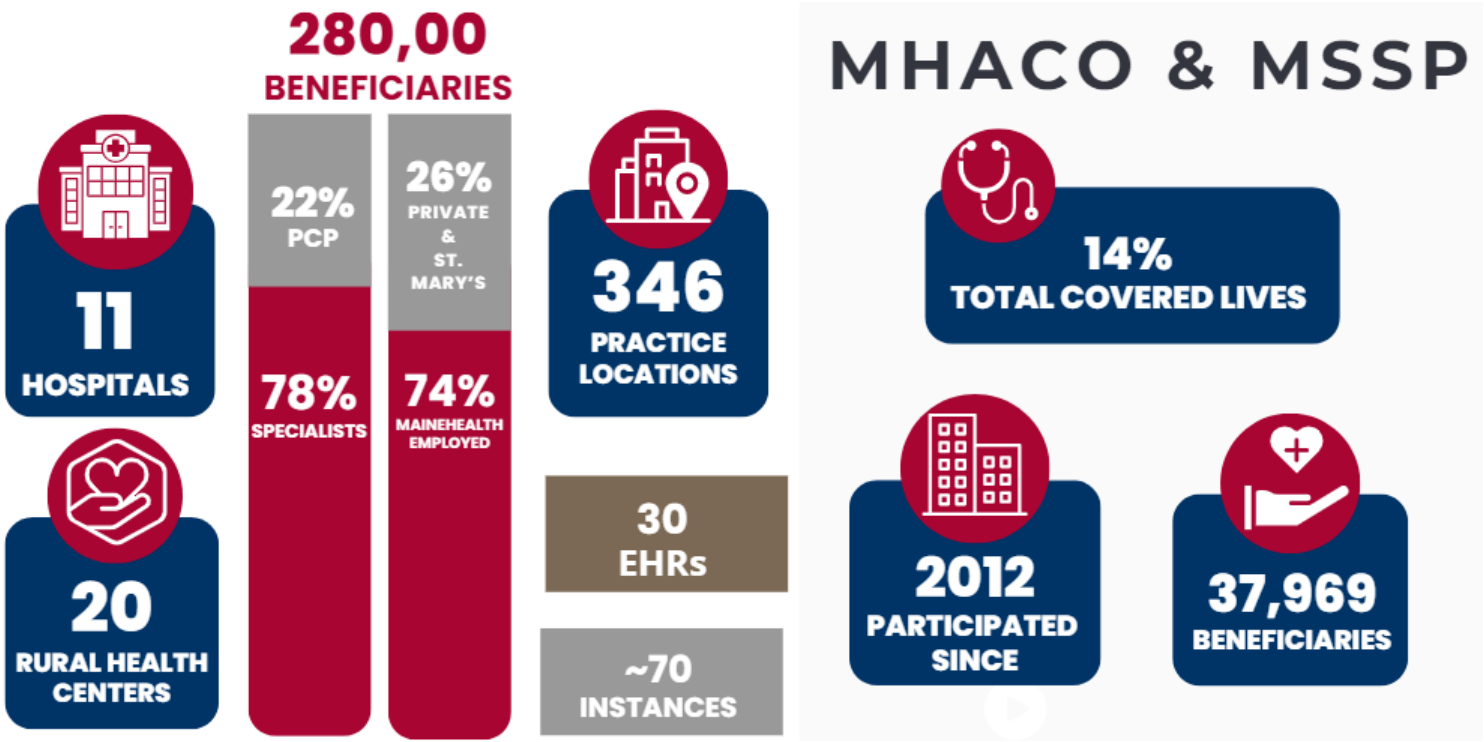
MSSP Digital Reporting Journey

Emily Levi, MaineHealth Accountable Care Organization

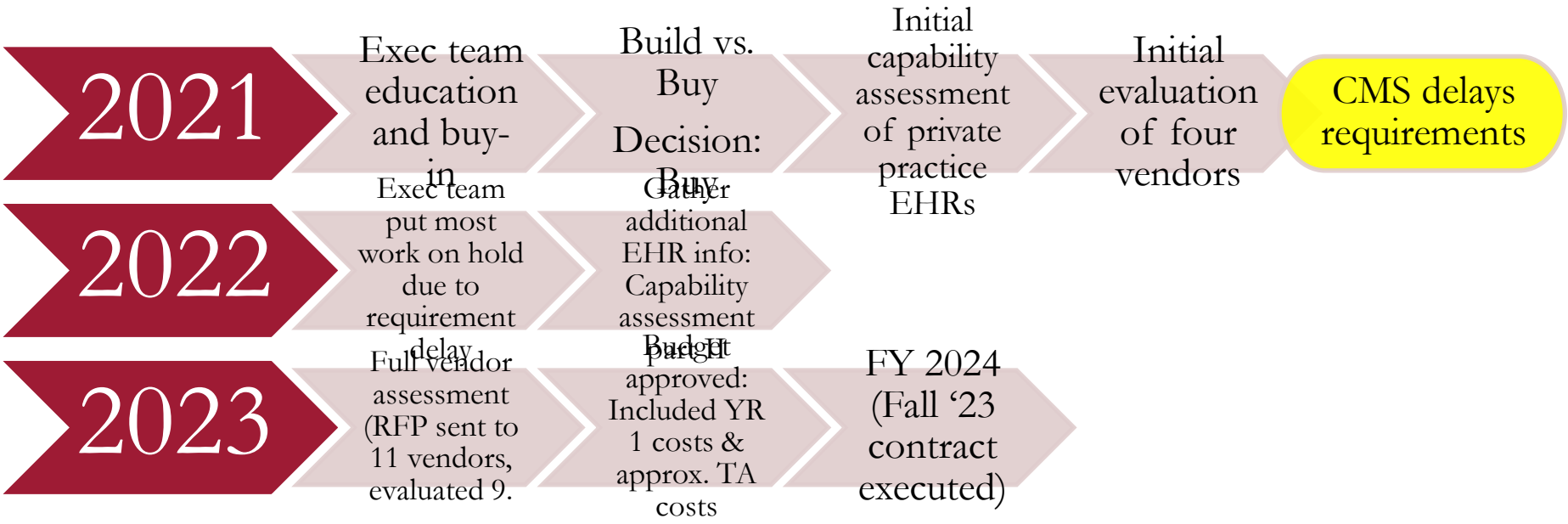
Outline

- Who is the MaineHealth Accountable Care Organization?
- Our journey: Contracting with a vendor
- Decision: Reporting type
- Reporting timeline for 2023 – 2025
- Challenges and how we plan to address them
- Three key takeaways

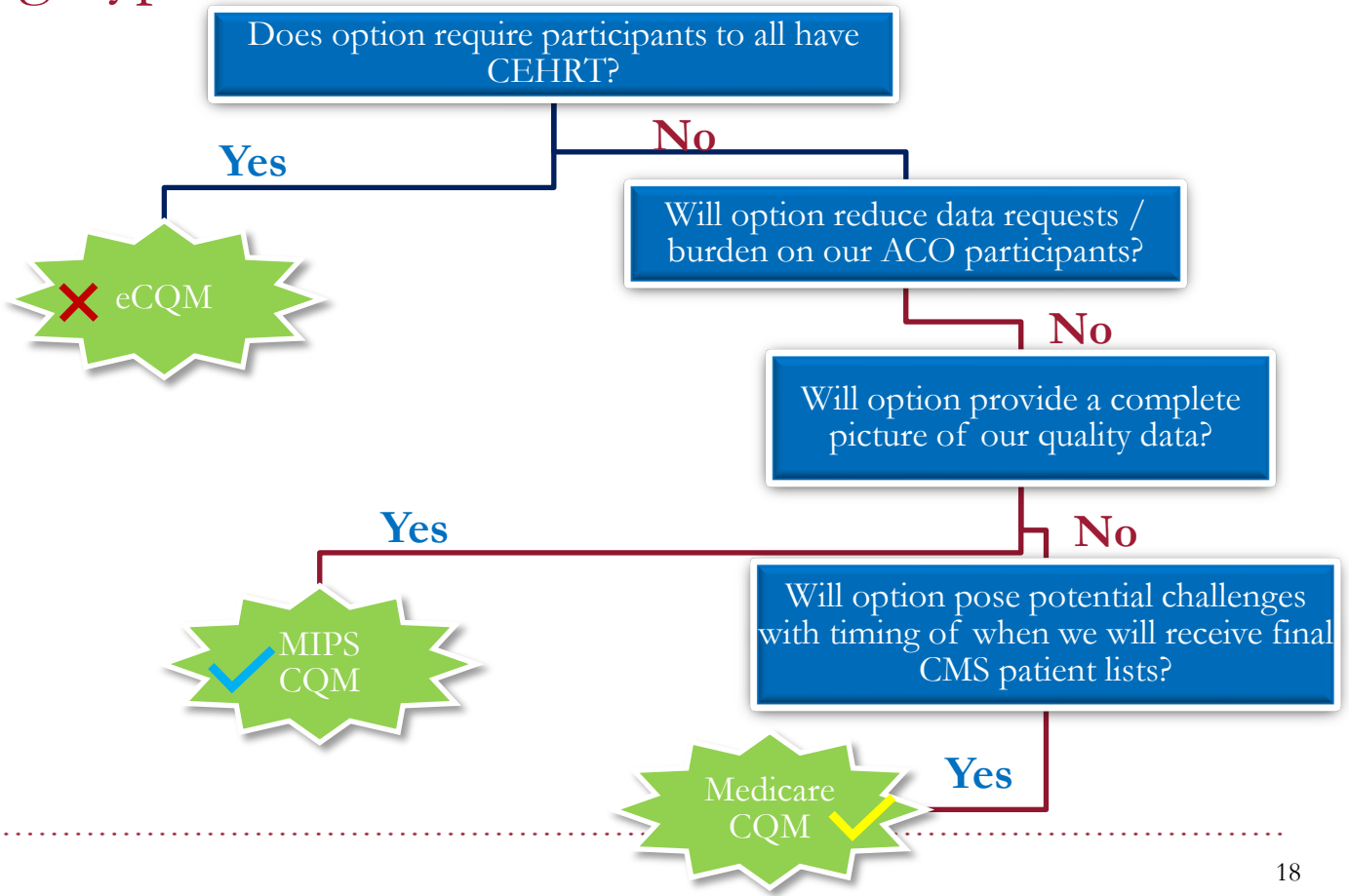
MaineHealth ACO Fundamentals



The Start of our Digital Reporting Journey



PY 2024 Reporting Type Decision



Timeline

Vendor Onboarding

Q4 2023

Action Items

- Collect test files
- Amp up education campaign
- Start process of FHIR connections with major TINs
- MIPS CQM decision

Collect Test Files

Q1 2024

Action Items

- Continue to collect test files from practices

Review performance

Q2 2024

Action Items

- Finish collecting data files
- Compare performance against expectations
- Begin to correct errors
- Implement FHIR connections with private practices

Document Improvement

Q3 2024

Action Items

- Identify documentation improvement opportunities

Q4 2024

Action Items

- Continue improvement opportunities

Dual Submissions

Q1 2025

Action Items

- Dual submission (WI & MIPS CQM)
- Finalize if we will also submit Medicare CQMs

Challenges and How We Have Addressed Them

Collecting data files from our private practices

- Establish FHIR connection, when possible, to limit QRDA collection to once per year
- Collect various file types (QRDA I or excel)
- Aim to understand entire denominator by collecting QRDAs & panel size data
- Offer for ACO to gain direct access to EHR to support practice

Large number of specialists in our ACO

- Initially request patient lists only
- Create specialist gap lists & only reach out if patients were not seen in MH Epic or by other ACO participants
- Run report on MH Epic patients to better understand how MH specialists are impacting CQM performance
- Use QRDA IIIs to better understand entire denominator

Depression Screening Measure

- MH-wide education to all providers regarding documenting follow-up
- On-going challenge of MH specialists unable to document a referral to a PCP in the EHR
- System-wide advocacy to include specialists in depression screening initiatives and quality metrics
- Non-MH specialists often not screening or documenting- in PY 2024 will prioritize accurate documentation of screening and follow-up

Changing CEHRT requirements

- Continue to evaluate whether we will require all our participants to meet new MSSP and MIPS CEHRT requirements

Key Takeaways

- Offer flexible data collection options to participants (e.g., FHIR).
- Provider education should start early and be on-going.
- Meet specialists where they are at.
- Executive support early on is critical.

Contact

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Thank you!

Providence
Population Health Management

A Clinical Data Exchange Success Story: How Standardization Improves Value Based Care Performance

January 24, 2024

Where can health plans get clinical data?

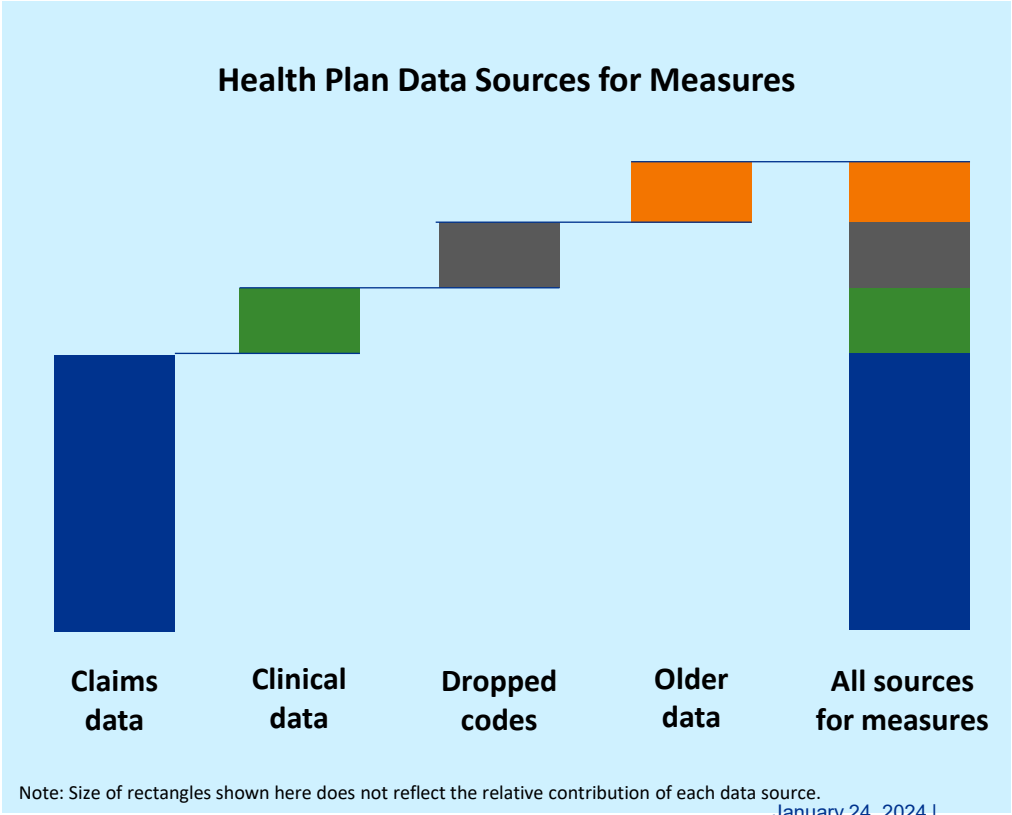
Health plans need access to clinical information beyond what they receive from provider billing data. They get it through:

- EMR chart pulls
- EMR platforms (e.g., Epic Payer Platform)
- Health plan-provided Annual Wellness Visits (AWVs)
- Lab companies (e.g., Quest and Labcorp)
- **Supplemental clinical data from providers**
- Other locations

Why is data from the provider billing process insufficient?

Adjudicated claims data alone is insufficient for health plans because:

- Provider billing data is **missing some clinical data** elements (e.g., HbA1c results)
- Sometimes usable **codes are dropped** during the billing process
- Some clinical measures have **long lookback periods** (up to 10 years)



What is supplemental clinical data?

Supplemental clinical data includes information on healthcare services, lab results and vital signs that are often unavailable through the provider billing process.

Why do health plans need supplemental clinical data?

- It helps them perform on **HEDIS** and **5-Star measures**
- It can support **care management** and transitions of care
- It allows health plans and providers to have a **shared understanding of patient needs**

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How can health plans ingest clinical data?

Health plans ingest clinical data outside of the billing process in a few ways.

EMR & vendor Platforms

Non-standard flat files

EMR patient charts

Data entry into web portals

CDex, DEQM & other IGs

How we used to deliver supplemental clinical data

We supplied supplemental clinical data in delimited flat files.

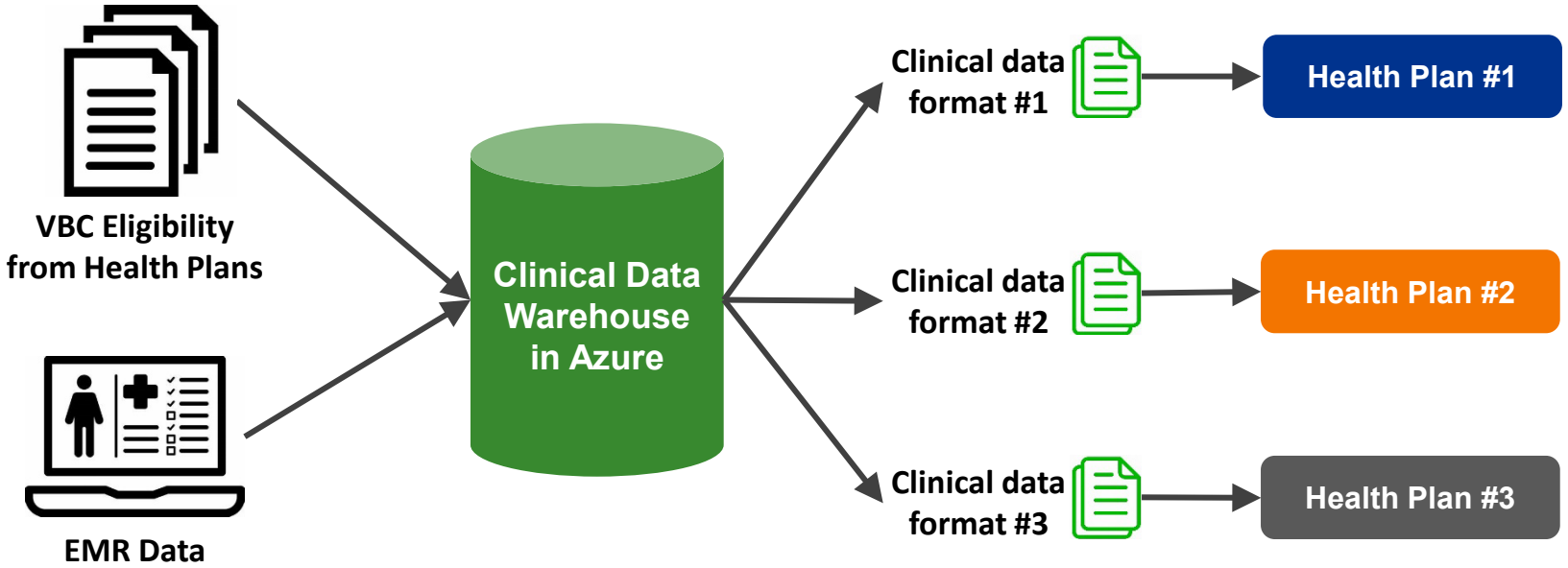
Health plans tend to use one of three HEDIS engines to process data, and their auditors have varying requirements, meaning they often requested:

- Similar data but in **different formats**
- **Additional fields** beyond those in our standard format
- **Separate feeds** for external claims

Column Name	Example
PersonID	123456
MemberID	999999999
PatientLastName	Cruise
PatientFirstName	Tom
PatientDOB	19700101
PatientSexCD	M
EncounterID	123456
ServiceType	HBD
DateOfService	5/15/19
ResultValue	5.5
ResultUnit	%
NormalRangeLowLimit	4.8
NormalRangeHighLimit	5.6
LOINCcode	4548-4
CPTCode	45380
CPTCodeII	3078F
ExternallyResulted	Y
ServicingProviderLastName	Smith
ServicingProviderFirstName	John
ServicingProviderNPI	123456789
EpicInstanceCD	4007
SourceInstanceCD	S99999
FileExtractionDate	10/23/19
Other fields	

Previous state of supplemental clinical data exchange

Providence submits supplemental clinical data to **15 payers** for **62 value-based care (VBC) arrangements**.



Just announced

Providence becomes the first major health system to implement HL7® Da Vinci Project's Clinical Data Exchange (CDex) standards.

- Partnership between Providence and Premera
- We used CDex to exchange clinical quality data from the EMR to support HEDIS and 5-Star measures

Link to press release: https://blog.providence.org/leadership-perspectives/providence-becomes-first-major-health-system-to-implement-hl7-da-vinci-project-s-clinical-data-exchange-standards

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RENTON, Wash., November 14, 2023 – Providence today announced the health system is the first in the country to build an HL7® Fast Healthcare Interoperability Resources (FHIR®) driven data-as-a-service (DaaS) product that facilitates the exchange of clinical data between providers and payers. The system-wide standardization of clinical data will ease the delivery of value-based care (VBC) to patients in a way that alleviates administrative and financial burdens.

Traditionally, one of the most significant barriers to seamless clinical data exchange has been the lack of standardization and automation. In many cases, payers and providers compile data in spreadsheets, share this information via email or secure file transfer protocol (SFTP) and then manually review each record. This process is time-consuming, prone to human error and in need of a solution.

The FHIR standard — which defines how health care information can be exchanged between different computer systems — makes clinical and administrative data available in a standardized and secure format to help reduce inefficiencies and increase quality of care. Providence's DaaS product leverages the Member Attribution (ATR), Clinical Data exchange (CDex) and Bulk Implementation Guides as national data exchange standards developed through HL7 Da Vinci Project, an industry-led project to enhance data sharing between payers and providers to enable the industry's transition to value-based care. By allowing health systems, payers and patients to seamlessly connect and share data when and where it is needed most, patient records, treatment plans and critical information can flow smoothly and securely.

"Interoperability is critical within value-based care, and FHIR integration allows health care organizations to exchange comprehensive clinical data that enables more accurate risk assessments, enhances care coordination and captures outcomes more effectively," said Michael Westover, vice president of population health informatics at Providence. "By using a national standard for contract gap closure and capturing the much-needed clinical data, we empower all stakeholders in their ecosystem to make more informed decisions, improve patient outcomes and enhance the overall quality of care to our patients – who are always at the center of all our efforts."

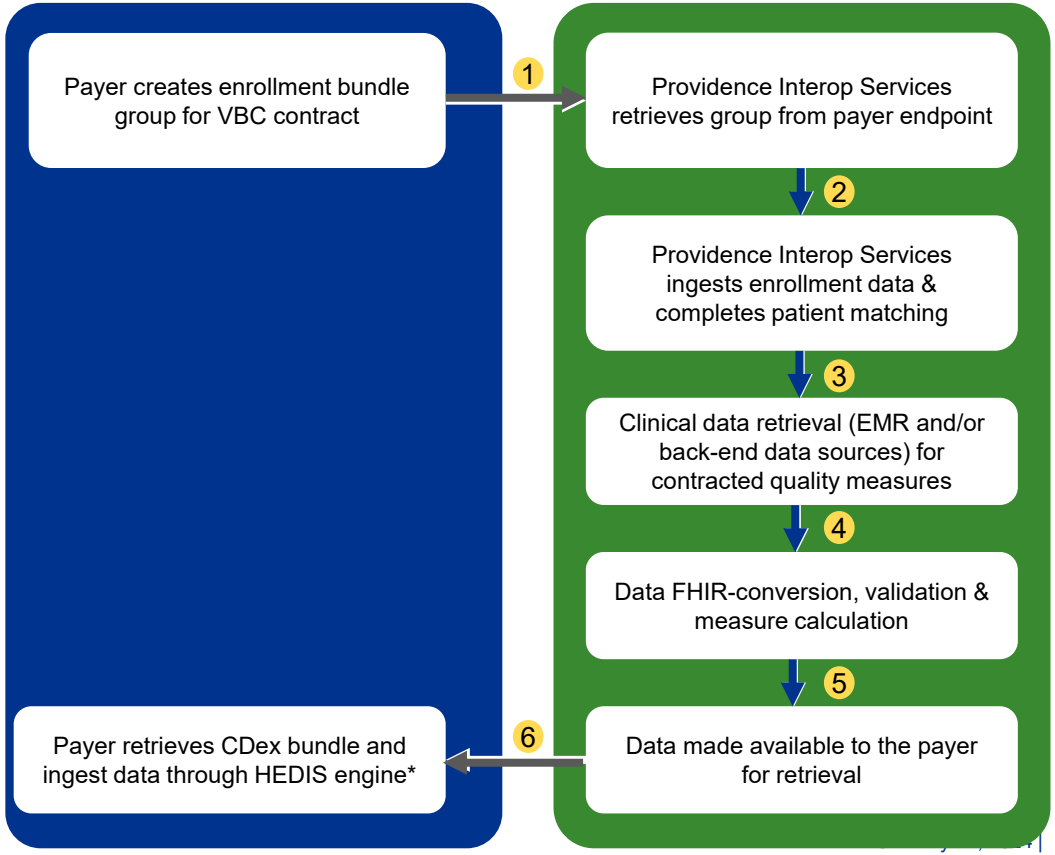
In September 2023, Providence piloted the product with Premera Blue Cross, one of the largest health plans in the Pacific Northwest, during which the product was thoroughly vetted and approved by internal quality teams and external Healthcare Effectiveness Data and Information Set (HEDIS) auditors.

Paving the way for industry-wide innovation, Providence has designed this solution to be scalable and adopted by other providers, ensuring payer partners have access to cutting-edge technology that supports growth and success in value-based care and beyond.

How we deliver supplemental clinical data now

Providence now uses health plan eligibility information in the FHIR ATR Implementation Guide (IG) to produce supplemental clinical data in a CDex format for health plans.

- Each enrollment request has a standard security (OAuth 2.0) validation process with a short-lived access token.
- Same security process applies to health plans requesting clinical data from Providence Interop Services.
- Health plan has a ClientID and secret code that is presented with each request.



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What clinical data do we deliver using CDex?

Production

- **BCS & BCS-E:** Breast Cancer Screening
- **BPD:** Blood Pressure Control for Patients with Diabetes
- **CBP:** Controlling High Blood Pressure
- **CCS:** Cervical Cancer Screening
- **COL & COL-E:** Colorectal Cancer Screening
- **KED:** Kidney Eval for Patients w/ Diabetes
- **HBD**: Hemoglobin a1C Control for Patient with Diabetes
- **OMW:** Osteoporosis Management in Women Who Had a Fracture
- **OSW:** Osteoporosis Screening in Older Women

Development (Est. Q1 2024)

- **EED:** Eye Exam for Patients with Diabetes
- **FMC:** ER F/U for Patients with Multiple CC
- **DMS-E, DRR-E, DSF-E :** one of three Depression Screening Measures

Planning for 2024

- **IMA & IMA-E, CIS & CIS-E, AIS-E:** Immunization Measures
- **PCR:** Plan All Cause Readmissions
- **SPD:** Statin Therapy for Patients w/ Diabetes
- **WCV:** Child & Adolescent Well-Care Visits
- Remaining **depression screening** measures

Why payers can trust supplemental clinical data

Health plans are willing to use our supplemental clinical data for HEDIS and 5-Star measures because:

- We share **share test data** and agree on formats during contract negotiations with health plans
- We **share a few samples of patient charts** from the EMR with data that matches the supplemental clinical data feed
- Health plans can **establish provenance** for the data
- We provide **data dictionaries** and descriptions for how to use the data
- We have a **history of passing audits** with these health plans

What is coming soon?

Here are a few of the improvements we are making to our supplemental clinical data in 2024.

- We are adding **more data elements** supporting more measures
- We are supporting **broader populations** outside of value-based care arrangements
- We are supporting task-based or **individual patient queries**

Why supplemental clinical data matters

Supplemental clinical data helps providers and health plans better manage patients, and it can have a financial impact on our organizations.

Success Example

VBC contract type: Medicaid

Population size: ~90k members

We submitted supplemental clinical data near the 2022 submission deadline for six patients, which pushed us over the threshold and allowed us to qualify for an additional $2M in incentives and $10M for the population during 2022.

Failure Example

VBC contract type: Medicare Advantage

Population size: ~8k members

We were two patients away from moving from 4.5 Stars to 5 Stars for the population, which would have helped in contract negotiations and quality bonuses.