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MACRA, QPP, MIPS... more alphabet soup anyone?
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>ACI</td>
<td>Advancing Care Information</td>
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<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
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<tr>
<td>APM</td>
<td>Advanced Alternative Payment Model</td>
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<tr>
<td>APRN</td>
<td>Advance Practice Registered Nurse</td>
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<tr>
<td>CMS</td>
<td>Center for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<tr>
<td>CPIA</td>
<td>Clinical Practice Improvement Activities (also called IA – Improvement Activities)</td>
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<tr>
<td>CRNA</td>
<td>Certified Registered Nurse Anesthetist</td>
</tr>
<tr>
<td>CY</td>
<td>Calendar Year</td>
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<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<td>KHIMA</td>
<td>Kansas Health Information Management Association</td>
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<tr>
<td>MACRA</td>
<td>Medicare Access &amp; CHIP Reauthorization Act of 2015</td>
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<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
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<tr>
<td>MIPPA</td>
<td>Medicare Improvements for Patients and Providers Act</td>
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<td>MIPS</td>
<td>Merit-based Incentive Payment System</td>
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<td>MMSEA</td>
<td>Medicare, Medicaid and SCHIP Extension Act</td>
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<td>MSSP</td>
<td>Medicare Shared Savings Program</td>
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<td>QCDR</td>
<td>Qualified Clinical Data Registry</td>
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<td>QPP</td>
<td>Quality Payment Program</td>
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<tr>
<td>QP</td>
<td>Qualified Participant</td>
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<tr>
<td>PA</td>
<td>Physician Assistant</td>
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<td>PQRI</td>
<td>Physician Quality Reporting Initiative</td>
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<td>PQRS</td>
<td>Physician Quality Reporting System</td>
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<td>PY</td>
<td>Performance Year</td>
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<td>SCHIP</td>
<td>State Children’s Health Insurance Program</td>
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<tr>
<td>SGR</td>
<td>Sustainable Growth Rate</td>
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<tr>
<td>TRHCA</td>
<td>Tax-relief and Health Care Act</td>
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<tr>
<td>VBM</td>
<td>Value-based Payment Modifier</td>
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### Historical Journey of the Clinician Quality Program

- **2006 legislation introduced the Physician Quality Reporting Initiative (PQRI) which began in 2007**
- **2007 legislation extended program to 2009**

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**Summit on Quality**

May 4, 2018

**Afternoon breakout #1**
Historical Journey of the Clinician Quality Program, continued

Medicare Improvements for Patients and Providers Act (MIPPA) in 2008

Patient Protection and Affordable Care Act (ACA) of 2010

- MIPPA made the program permanent, changed the name to Physician Quality Reporting System (PQRS) and authorized incentive payments through 2010
- 2010 legislation extended payments through 2014 and established mandatory reporting in 2015, otherwise penalties ensued

First Year of QPP participation 2017

- In April of 2015, MACRA became law which led to the establishment of the Quality Payment Program (QPP)
Quality Payment Program

MACRA legislation in April 2015
- Repeal of Sustainable Growth Rate (SGR)
- Established Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

Advanced Alternative Payment Models (APMs)

Example of APMs: Accountable Care Organization (ACO) or Medicare Shared Savings Program (MSSP)
Eligible clinicians include the following who bill Medicare Part B:
- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Physician Assistant (PA)
- Advance Practice Registered Nurse (APRN)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)

Eligible Clinicians receive +/- payments based on performance in four areas:
- Quality
- Advancing Care Information
- Improvement Activities
- Cost
MIPS 2017

- Quality (60%)
- Improvement Activities (15%)
- Advancing Care Information (25%)
- Cost (0%)

MIPS 2018

- Quality (50%)
- Improvement Activities (15%)
- Advancing Care Information (25%)
- Cost (10%)
Quality Payment Program - MIPS

- Report as individual or group
- Report via one of the following ways
  - Claims
  - Registry or Qualified Clinical Data Registry (QCDR)
  - Electronic Health Record (EHR)
  - CMS Web-interface

Three previous programs (PQRS, MU and VBM) were rolled into one MIPS program

- First year of participation - 2017
- First year of reporting - 2018
- Based on 2017 performance, will impact payment in CY 2019
Quality Payment Program - MIPS

Performance year (PY) = Jan. 1 – Dec. 31

Report for Performance year – by March 31st
Quality Payment Program - MIPS

**WHY?**

- Improve quality of care
- Decrease cost
- Improve health/patient outcomes
- Improve care information and exchange

Quality Payment Program - MIPS

**HOW?**

Payments for performance (not volume):
- +/- 4% in 2019
- +/- 5% in 2020
- +/- 7% in 2021
- +/- 9% in 2022
Advanced Alternative Payment Models (APMs)

- Focused on care episode or certain patient population (risk-based model)
- Must apply for participation in APM
- 5% annual incentive for meeting criteria relating to quality and cost
- Eligible Clinicians can participate:
  - APM only (as a Qualified Participant – QP)
  - combination of MIPS/APM

Volume to Value

- Patient at center of care
- Payment based on providing higher quality, lower cost and better outcome care
- Payment on episode of care and other APMs
- Population health
Resources

https://qpp.cms.gov/


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Quality Validation

Acronyms

- ACI  Advancing Care Information
- APRN  Advanced Practice Registered Nurse
- CMS  Centers for Medicare and Medicaid Services
- DO  Doctor of Osteopathy
- EC  Eligible Clinicians
- EH  Eligible Hospital
- EHR  Electronic Health Record
- IQR  Inpatient Quality Reporting
- LMH  Lawrence Memorial Hospital
- MD  Medical Doctor
- MIPS  Merit-based Incentive Payment System
- MU  Meaningful Use
- PA  Physician Assistant
Lawrence Memorial Hospital

- 174 bed, community-owned, not-for-profit hospital located in Lawrence, KS
- Healthcare’s Most Wired Hospital for 7 years
- Joint Commission Accredited organization
- HIMSS Stage 6 for the hospital and for clinics

LMH Physicians and Clinics

- Total number of clinicians (MDs, DOs, APRNs, PAs): 156
- Total number of clinics: 23
  - 9 Family Practice/Internal Medicine clinics
  - 14 Specialty clinics
Validation and Accountability

- Documentation purposes
- Audit readiness
- Transparency to end users
  - Send weekly ACI and Quality measures reports to clinic directors/managers
  - Reports are reviewed with staff and providers

Our EC Validation Team ~ Skill Sets

- **Clinical Informatics Specialist**
  Workflow expertise, knowledge of clinical and documentation practices
- **Outcomes Coordinator**
  Regulatory knowledge of incentives from third party payers, regulatory knowledge expertise
- **Data Analyst**
  Prepares, analyzes, and distributes weekly reports for Quality and ACI measures
- **Application Analyst**
  Comprehensive knowledge of filters, builds necessary EHR components, package management, manages technical details/processes
- **Meaningful Use Manager**
  Regulatory knowledge of MU, MIPS, coordinates logistics, maintains documentation, creates validation tools, tracks validation efforts, attests for MIPS and MU
Validating Quality measures for ECs

• 2015
  • Tools
    • CMS Value set
    • Standards for each measure
    • Team of 3 “on a mission”
  • Work Effort
    • Configured filters
    • Created test scenarios
    • Created test patients
    • Ran reports
    • Validated report content against documentation in the chart

Validating Quality measures for ECs

• 2015
  • Pros
    • Got it done
  • Cons
    • Labor intense
    • Not using real patients
    • Scenarios less complex
  • Lesson Learned
    • Has to be a better way
Validating Quality measures for ECs

- 2016
  - Tools
    - Learned vendor had designed a validation tool
      - Spreadsheet with tab for each measure
      - Tab had columns containing criteria for meeting exceptions, denominator, numerator, etc.
      - Vendor ran reports
      - Data from reports pasted into spreadsheet by measure
      - Became obvious very quickly, tool needed modifications to be useful
  - Modified Tool
    - Validation Team modified the tool
      - Created separate spreadsheet for each measure
      - Added tab with copy of the CMS value set for specific measure
      - Added tab with copy of standard for specific measure
      - Added tab with copy of flowchart
  - Work Effort
    - Met with vendor to modify filters
    - Pasted in report content to each spreadsheet
    - Validated spreadsheet against charted documentation
    - Created an Issues spreadsheet

- Pros
  - Much smoother process
  - Could assign team members different measures
  - All resources for measure located in one spreadsheet
  - Used real patient data

- Cons
  - Work effort for LMH to build each spreadsheet

- Lesson Learned
  - Request vendor build individual spreadsheets for each measure
    - Include tabs for CMS Value set, Measure specifications, Flowcharts
Validating Quality measures for ECs

2017

Tools
- Received vendor’s validation tool with requested changes
- Enhanced “Issues” spreadsheet, with tabs identifying the measure

Work Effort
- Met with vendor to modify filters
- Pasted in report content to each spreadsheet
- Validated spreadsheet against charted documentation
- Transferred issues to separate spreadsheet

Pros
- Significant times savings for Validation Team
- Issues spreadsheet made troubleshooting with vendor more efficient
- Consistent workflow for validation

Cons
- Have to go into application to see how filters are configured

Lesson Learned
- The more we improve the process, the more opportunities we see for improvement
Our EH Validation Team ~ Skill Sets

- **Clinical Informatics Specialist**
  Workflow expertise, knowledge of clinical and documentation practices
- **Clinical Excellence Manager**
  Regulatory knowledge expertise, measure expertise
- **Application Analyst**
  Comprehensive knowledge of filters, builds necessary EHR components, package management, manages technical details/processes
- **Meaningful Use Manager**
  Regulatory knowledge of MU, coordinates logistics, maintains documentation, creates validation tools, tracks validation efforts, attests for MU

Validating Quality measures for EH

- **2015**
  - **Tools**
    - CMS Value set
    - Standard for each measure
    - Team of 1 “on a mission”
  - **Work Effort**
    - Trended values on a weekly basis
    - Compared reports to Quality department’s abstraction tool data
    - Identified and researched discrepancies
Validating Quality measures for EH

- 2015
  - Pros
    - Got it done
  - Cons
    - Labor intense
    - Comparing to abstraction tool was comparing apples to oranges
      - Sample vs population
      - Slight difference in IQR measures versus MU
  - Lesson Learned
    - Has to be a better way

- 2016
  - Tools
    - Team of 2
    - Vendor developed audit reports for measures
      - Report by measure
      - Patient information with columns for criteria to meet the measure populated with Yes/No
    - CMS Value Set
    - Standards for each measure
  - Modified Tool
    - Validation Team modified the tool
      - Added tab columns for Pass/Fail, Date of Validation, Notes, and Initials
      - Added tab with copy of standard for specific measure
      - Added tab with copy of flowchart
  - Work Effort
    - Validated spreadsheet against charted documentation
Validating Quality measures for EH

2016
- **Pros**
  - Much smoother process
- **Cons**
  - Still didn’t have all resources in one document
- **Lesson Learned**
  - Request vendor create template for each measure
    - Include tabs for CMS Value set, Measure specifications, Flowcharts

2017
- **Tools**
  - Received vendor’s validation tool with requested changes and more!
    - Included screen shots of our filter configuration in the measure algorithm
    - Hyperlinked the measures specs to a separate Value set tab
- **Work Effort**
  - Validated spreadsheet against charted documentation
- **Pros**
  - Went from two person validation to one person
  - Consistent workflow for validation
- **Cons**
  - No complaints!!
- **Lesson Learned**
  - The more we improve the process, the more opportunities we see for improvement
Pitfalls to avoid

- Not knowing what to expect from your vendor
  - May seem obvious, but if you have consulting services with your vendor, make sure you know what is included in their services
- Know what tools, if any, your vendor has
  - If none, work with vendor to create tool
  - If tool exists, ensure it meets your needs
- For validation purposes, it is most efficient to either:
  - Have all necessary resources in one document, or
  - Have all necessary resources open and available
- Not tracking progress/status of validation process
  - Develop a spreadsheet for organizing your work efforts
- Lack of redundancy/depth in team’s skills
  - Knowledge sharing vs knowledge silos
- Lack of accessibility to files
  - Have common drive/file

Challenges

- Changes in team members
  - Knowledge transfer
  - Orienting new team members
- Deciding what is an appropriate number of patients to validate for each Outcome
  - Met/Done
  - Not Met/Not Done
  - Denominator Exclusion
  - Denominator Exception
  - IPP only
- Iterative process
- Package management and when to validate
  - Trying to avoid continuous re-validation efforts after new packages are installed
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