How IT Leaders Can Reduce Reporting Burden, Boost Incentives

Session 413, March 8, 2018

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Conflict of Interest

Ed Bolding, MA
Has no real or apparent conflicts of interest to report.

Ye Hoffman, MS, CPHIMS
Salary: The Advisory Board
Agenda

• Overview of CMS Quality Reporting Requirements
• Notable 2018 Quality Payment Program Policies
• IT Correlates to Quality Performance Management
Learning Objectives

• Describe quality reporting requirements, and alignment opportunity among other CMS quality reporting programs
• Identify how to reduce quality reporting burden and optimize IT capabilities
• Discuss the evolving role of IT in quality reporting strategy
• Formulate a sustainable framework for a coordinated, IT-driven quality reporting initiative
Major CMS Quality Reporting Programs

Medicare Payments Tied to Reporting, Performance, and Use of Health IT

Hospital Inpatient Quality Reporting (IQR)

The MMA authorized CMS to pay hospitals that report designated quality measures a higher annual market basket update to their Inpatient Prospective Payment System (IPPS) rates.

EHR Incentive Programs aka Meaningful Use (MU)

The HITECH Act enacted as part of ARRA established the EHR Incentive Programs, which incentivizes hospitals and providers to adopt meaningful use of certified EHR technology (CEHRT).

Quality Payment Program (aka MIPS/APM)

MACRA fundamentally changes how Medicare pays clinicians through the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) payment tracks.

Potential Penalties in 2019 Tied to 2017 Performance

-25% Reduction to IPPS Market Basket Update

-75% Reduction to IPPS Market Basket Update

-4% Reduction to Medicare Part B Reimbursement

Source: Advisory Board research and analysis.

1) CMS = Centers for Medicare & Medicaid Services
2) MACRA = Medicare Access and CHIP Reauthorization Act of 2015.
3) HITECH = Healthcare Information Technology for Economic and Clinical Health Act.
# MU Reporting Requirements

2014 Edition CEHRT Allowed and Stage 3 Optional in 2017 and 2018

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Medicare and Medicaid Hospitals</th>
<th>Medicaid EPs&lt;sup&gt;4&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MU</strong></td>
<td>• Any continuous 90 days within the calendar year</td>
<td>• Either Modified Stage 2 or Stage 3 measure set finalized in the October 2015 MU rule</td>
</tr>
<tr>
<td>Measure Set</td>
<td>• Either Modified Stage 2 or Stage 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Medicare and dually-eligible hospital measure set finalized in 2017 OPPS rule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Medicaid-only hospital measure set finalized in the October 2015 MU rule</td>
<td></td>
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<tr>
<td><strong>CQM&lt;sup&gt;1&lt;/sup&gt;</strong></td>
<td>• Electronic reporting via QualityNet: Any one calendar quarter</td>
<td>• Any continuous 90 days within the calendar year regardless of submission method allowed by the state</td>
</tr>
<tr>
<td>Reporting Period</td>
<td>• Manual attestation&lt;sup&gt;2&lt;/sup&gt;: Full calendar year</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>• Electronic reporting via QualityNet: 4 out of 16 available CQMs&lt;sup&gt;3&lt;/sup&gt;</td>
<td>• 6 out of 53 available measures&lt;sup&gt;5&lt;/sup&gt; regardless of submission method allowed by the state</td>
</tr>
<tr>
<td></td>
<td>• Manual attestation&lt;sup&gt;2&lt;/sup&gt;: All 16 available CQMs</td>
<td></td>
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</tbody>
</table>

1) CQM = Clinical quality measure; 2) Beginning 2018, manual attestation is no longer an option for hospital MU, unless electronic submission is infeasible; 3) If reporting electronically to align with IQR, only 15 electronic clinical quality measures (eCQMs) are available because the ED-3 measure is not considered an inpatient measure for IQR; 4) For Medicaid EPs in 2018, CMS finalized MU reporting requirements, but will release eCQM reporting requirements in future rulemaking; 5) CMS aligned the Medicaid EP CQM requirements with those available to report from an EHR for MIPS.

Sources: CMS; Advisory Board research and analysis.
## IQR eCQM Reporting Requirements

<table>
<thead>
<tr>
<th>Reporting Requirements</th>
<th>CY 2016</th>
<th>CY 2017</th>
<th>CY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of eCQMs that a hospital must report</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Number of available eCQMs from which to choose</td>
<td>28</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Reporting period</td>
<td>One Quarter (Q3 or Q4 of CY 2016)</td>
<td>One Quarter (Q1, Q2, Q3 or Q4 of CY 2017)</td>
<td>One Quarter (Q1, Q2, Q3 or Q4 of CY 2018)</td>
</tr>
<tr>
<td>Electronic specifications version¹</td>
<td>May/June 2015</td>
<td>April 2016 and January 2017 addendum</td>
<td>May 2017</td>
</tr>
</tbody>
</table>

Electronic reporting of eCQMs is just one of the IQR requirements. Hospitals must ensure that they fully satisfy all requirements to prevent payment adjustment.

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1) Electronic specifications are available at https://ecqi.healthit.gov/.

Sources: CMS; Advisory Board research and analysis.
## MACRA Quality Payment Program

### Advanced Alternative Payment Models (Advanced APM)
- **Financial incentives**: 5% annual lump-sum bonus in 2019–2024, and 0.75% annual fee-for-service payment increase from 2026 onward
- **Exempt from MIPS payment adjustments**

### Merit-Based Incentive Payment System (MIPS)
- **Performance based on 4 categories**: Quality, Cost, IA, and ACI
- **Payment adjustments** to Medicare Part B fee-for-service reach -9% / +27% by 2022

### 2018 QPP Final Rule Key Takeaways

1. **More participants**, more payment model options in 2018
2. **No maximum provider limit** for Round 1 CPC+ participants
3. **All-Payer Combination** APM option details available, starting QPP Year 3

### Exclusions expanded, results in more providers excluded from MIPS
1. **Framework maintained**, many category requirements remain as-is
2. **Quality and Cost category changes**, key determinant of highest performing ECs

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1) IA = Improvement Activities category; 2) ACI = Advancing Care Information; 3) CPC+ = Comprehensive Primary Care Plus; 4) ECs = Eligible Clinicians.

Sources: CMS; Advisory Board research and analysis.
Bipartisan Budget Act of 2018

Two Significant Changes to MIPS

“Transition” Years Under MIPS Expands

Certain “transition” year policies are extended through 2021

$ New Cost category weight flexibility; CMS can weigh the cost category anywhere between 10% and 30%

✅ Rewards for Cost category performance improvement are delayed

📈 Performance threshold (PT) to avoid the MIPS penalty will increase more gradually

MIPS Payment Adjustment Scope Changes

MIPS payment adjustments now only apply to Medicare Part B “covered professional services”

⚠️ The funding law updates MACRA to no longer apply MIPS adjustments to Medicare Part B “items and services” that would otherwise have included Part B drugs

Sources: Bipartisan Budget Act of 2018; Advisory Board research and analysis.
## 2018 MIPS Performance Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Policies Finalized</th>
<th>IT Opportunities</th>
<th>Weight¹</th>
</tr>
</thead>
</table>
| **Quality**               | • Six measures still required for most submission methods  
  • Reporting period increases to full calendar year  
  • Cap maximum points available for six topped-out measures  
  • Data completeness requirement increases to 60% for EHR, registry, and claims-based submission methods                                     | • Bonus points available for end-to-end electronic reporting of Quality data captured in CEHRT  
  • IT-enabled clinical documentation improvement can boost performance                                                                                                                   | 50%     |
| **Cost**                  | • Weight increases to 10% in 2018; previously 0% in 2017  
  • Based on claims data; no additional reporting required  
  • Assessed on Medicare Spending per Beneficiary (MSPB) and total per capita cost measures; episode-based measures to be proposed in future rulemaking                                                | • Leverage IT optimizations to improve Hierarchical Conditions Category (HCC) capture, crucial for accurate risk adjustment                                                                                     | 10%     |
| **Improvement Activities**| • No change to 90-day reporting  
  • Additional activities to choose from                                                                                                                                         | • Use of CEHRT to carry out improvement activities earns bonus points in ACI category                                                                                                                   | 15%     |
| **Advancing Care Information** | • No change to 90-day reporting period  
  • 2014 CEHRT² and ACI Transition measures still allowed  
  • Bonus for using 2015 Edition CEHRT only for ACI measures                                                                                                           | • No longer “all or nothing” scoring previously used in Meaningful Use; incremental performance improvement increases score  
  • Enhanced 2015 Edition CEHRT functionality focuses on bidirectional information exchange                                                                                           | 25%     |

1) Different weights apply to MIPS APM scoring standard;  
2) CEHRT = Certified Electronic Health Record Technology.

Sources: CMS; Advisory Board research and analysis.
### MIPS Gets Tougher by Law, by Design

<table>
<thead>
<tr>
<th>Year</th>
<th>QPP Year</th>
<th>At Risk</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Year 1</td>
<td>4%</td>
<td>Low performance bar, multiple reporting period options, Cost category weight at 0%</td>
</tr>
</tbody>
</table>
| 2018     | Year 2   | 5%      | Few changes, with most Year 1 flexibilities retained  
  - Year-long reporting period for Quality  
  - Cost category increases to 10%  
  - Retain Year 1 ACI measure and CEHRT requirements |
| 2019     | Year 3   | 7%      | Requirements to become gradually more challenging per future rulemaking  
  - Quality  
    - Full-year reporting period, and potentially higher data completeness thresholds  
  - Cost  
    - Weight may be between 10% to 30%; improvement scoring delayed  
  - ACI  
    - 2015 Edition CEHRT upgrade required to report Stage 3-equivalent, more difficult measures |

Source: CMS; Advisory Board research and analysis.
## IT is Central to Quality Performance Management

<table>
<thead>
<tr>
<th>Stages</th>
<th>Description</th>
<th>IT Correlates</th>
<th>Level of Execution</th>
</tr>
</thead>
</table>
| Quality Improvement   | Prioritize quality improvement projects to maximize patient outcomes, financial returns | 1. **Governance structure, with IT representation:** Establish an aligned quality reporting oversight committee  
2. **Data governance:** Define focused set of data and process management policies and ensure compliance | Strategic           |
| Quality Assurance     | Evaluate performance on ongoing basis to check improvement progress, avert end-of-year surprises | 3. **Data mapping/validation:** Specify unique data elements based on specifications and confirm data accuracy and completeness  
4. **Performance monitoring:** Identify performance improvement opportunities | Operational         |
| Quality Reporting     | Submit data to payers for quality performance evaluation                     | 5. **CEHRT configuration/reporting:** Build technical capabilities to support specific goals of quality reporting  
6. **Workflow modifications:** Provide means to improve data collection and provider engagement |                    |

Source: Advisory Board research and analysis.
About Northside Hospital System

- Three not-for-profit hospitals in Georgia, located in Atlanta, Forsyth and Cherokee, with a total of 926 licensed beds
- Northside Hospital-affiliated outpatient centers and medical office buildings throughout North Metro Atlanta
- More than 2,500 physicians on staff and more than 15,000 employees
- Approximately 20 Tax ID Number group across various specialties
- Nearly 2,500,000 patient encounters annually
- All Northside hospitals are full-service, acute-care facilities that offer particular expertise in Maternity Services, Women’s Health, Cancer Care, Surgery and Radiology

Source: Northside Hospital System.
Quality Reporting is a Team Sport

Key Players in Quality Reporting Governance Structure

**Policy Experts**
- Monitor regulatory changes and determine strategic and operational implications
- Educate leadership and front-line staff on relevant policies

**Clinical and Operational Leaders**
- Provide input to measure selection and clinical workflows
- Communicate performance to all relevant stakeholders
- Develop strategies to improve performance and drive staff adoption

**IT Department**
- Implement and configure IT systems to optimize data collection
- Support data extraction, mapping, consolidation, and reporting
- Provide technical guidance on performance reports

**Finance and Health Information Management**
- Understand and forecast reimbursement implications
- Optimize coding practices to support accurate documentation

Source: Advisory Board research and analysis.
Recognize Importance of Alignment

<table>
<thead>
<tr>
<th>PAST</th>
<th>FUTURE</th>
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</thead>
<tbody>
<tr>
<td>![Puzzle Piece]</td>
<td>![Handshake]</td>
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</tbody>
</table>

**Initiative-Based Structure**
- Fragmented quality reporting efforts driven by specific program requirements
- Potentially redundant, overlapping technical capabilities
- Duplicate efforts spent on similar technical and operational issues across programs

| 1 | Consider using MACRA, relevant regulations, and private payer quality reporting programs as a burning platform to drive change in quality reporting oversight structure |
| 2 | Identify internal stakeholders with clinical quality reporting experience and enlist them as champions |
| 3 | Establish a centralized quality reporting committee |

**Aligned Quality Reporting Governance**
- Decision-making authority to develop coordinated strategies and oversee quality reporting operations
- Collaboration among Quality, Clinical, IT, Compliance, and Finance leaders
- Streamlined efforts in strategic and operational executions

Source: Advisory Board research and analysis.
Northside’s MACRA “Dream Team”

Key Interdepartmental Players Driven by Comprehensive EHR Optimization

<table>
<thead>
<tr>
<th>Finance</th>
<th>Financial Strategy</th>
<th>Operations</th>
<th>Information Technology</th>
<th>Revenue Integrity / HIM¹</th>
<th>Contracting / Credentialing</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Director</strong>, Finance Value Based Care</td>
<td><strong>Director</strong>, Financial Strategy and Revenue Innovation</td>
<td><strong>Director</strong>, Physician Practice Management</td>
<td><strong>Director</strong>, Ambulatory Systems</td>
<td><strong>Director</strong>, Revenue Integrity / HIM¹</td>
<td><strong>Director</strong>, Managed Care (Credentialing)</td>
<td><strong>Director</strong>, Value Based Clinical Care</td>
</tr>
<tr>
<td><strong>VP</strong>, Managed Care</td>
<td><strong>Manager</strong>, PMO² and Finance Value Based Care</td>
<td><strong>Manager</strong>, Physician Practice Management</td>
<td><strong>Manager</strong>, Ambulatory Systems</td>
<td><strong>Manager</strong>, Revenue Integrity</td>
<td><strong>Manager</strong>, Managed Care (Credentialing)</td>
<td><strong>Coordinator</strong>, Value Based Clinical Care</td>
</tr>
<tr>
<td><strong>Senior Technical Analyst</strong></td>
<td><strong>Manager</strong>, Special Projects</td>
<td><strong>Senior Application Specialists</strong> (by platform)</td>
<td><strong>Senior Analysts</strong>, Revenue Integrity</td>
<td></td>
<td><strong>Coordinator</strong>, Clinical Informatics</td>
<td></td>
</tr>
<tr>
<td><strong>Senior Financial Analysts</strong></td>
<td><strong>Coordinator</strong>, Special Projects</td>
<td><strong>IT Coordinator</strong>, Quality Reporting</td>
<td></td>
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<td><strong>Specialists</strong>, Quality Education</td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>Senior Analysts</strong>, Special Projects</td>
<td></td>
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</tr>
</tbody>
</table>

1) HIM = Health Information Management.
2) PMO = Program management office.

Source: Northside Hospital System.
Best Supporting Role Goes to ... IT

"The importance that IT plays in success in Value-Based Care cannot be overstated. No longer can IT be considered an ancillary player in organizations’ revenue strategies. They should be considered an integral part of any effort to modernize reimbursement."

Dan Huffman, Director
Financial Strategy & Healthcare Reform, Northside Hospital System

Sources: Northside Hospital System; Advisory Board research and analysis.
Clinical Documentation Improvement

Empower Quality and IT to educate staff on:

- What is MIPS trying to accomplish?
- What are the performance requirements?
- How does it impact my work and my staff?
- How and where do I record the data?”

“...It’s not good enough that [the clinician] document it; we need you to document [in a specific] place where we can capture it for reporting."

A Study of the Impact of Meaningful Use CQMs, American Hospital Association

Education Approach

- Tie quality measures to strategic initiatives
- Educate all levels of clinical and operational staff, from lead clinicians to office staff
- Provide actionable performance feedback
- Implement IT optimizations and retrain staff
- Measure performance improvement

Documentation Support

- Utilize templates and structured electronic progress notes
- Train advanced practitioners to support electronic data capture
- Build IT solutions to capture relevant diagnoses across continuum of care, in order to optimize coding for risk adjustment

Sources: Northside Health System; Advisory Board research and analysis.
Evolve IT’s Role in Quality Reporting

Key Takeaways to Reduce Reporting Burden, Maximize Incentives

1. **Adapt** to changing quality reporting requirements
   Expect frequent regulatory changes as quality reporting requirements increasingly shift from volume to value

2. **Utilize** IT to enable quality reporting success
   Strengthen partnerships between quality and IT to implement technical solutions that support quality improvement, assurance, and reporting

3. **Align** quality reporting initiative across any siloes
   Reduce reporting burden and duplicative processes with an aligned approach across programs

4. **Evolve** IT’s role in quality reporting governance
   Place IT staff throughout governance structures to facilitate and strategize best reporting and performance improvement approaches

Source: Advisory Board research and analysis.
Commonly Used Acronyms

- **ACI**: Advancing Care Information
- **APM**: Alternative Payment Model
- **Advanced APM**: APM potentially eligible for APM track incentives
- **CEHRT**: Certified Electronic Health Record (EHR) Technology
- **CMS**: Centers for Medicare & Medicaid Services
- **EC**: Eligible Clinician, a provider subject to MACRA
- **eCQM**: Electronic Clinical Quality Measure
- **EP**: Eligible Professional
- **IA**: Improvement Activities
- **IPPS**: Inpatient Prospective Payment System Rule
- **IQR**: Inpatient Quality Reporting
- **MACRA**: Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015
- **MU**: Meaningful Use
- **MIPS**: Merit-based Incentive Payment System
- **OPPS**: Outpatient Prospective Payment System Rule

Source: Advisory Board research and analysis.
Questions

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