Leveraging the Quality Payment Program as a Successful Tool for Patient-Centered Care

December 8, 2018

Objectives

- Define the categories of the Quality Payment Program (QPP) as they relate to practice improvement in primary care
- Explain the connection between the QPP categories and their relationship to practice improvement
- Develop practice improvement activities that use the synergies between QPP categories to improve patient-centered care

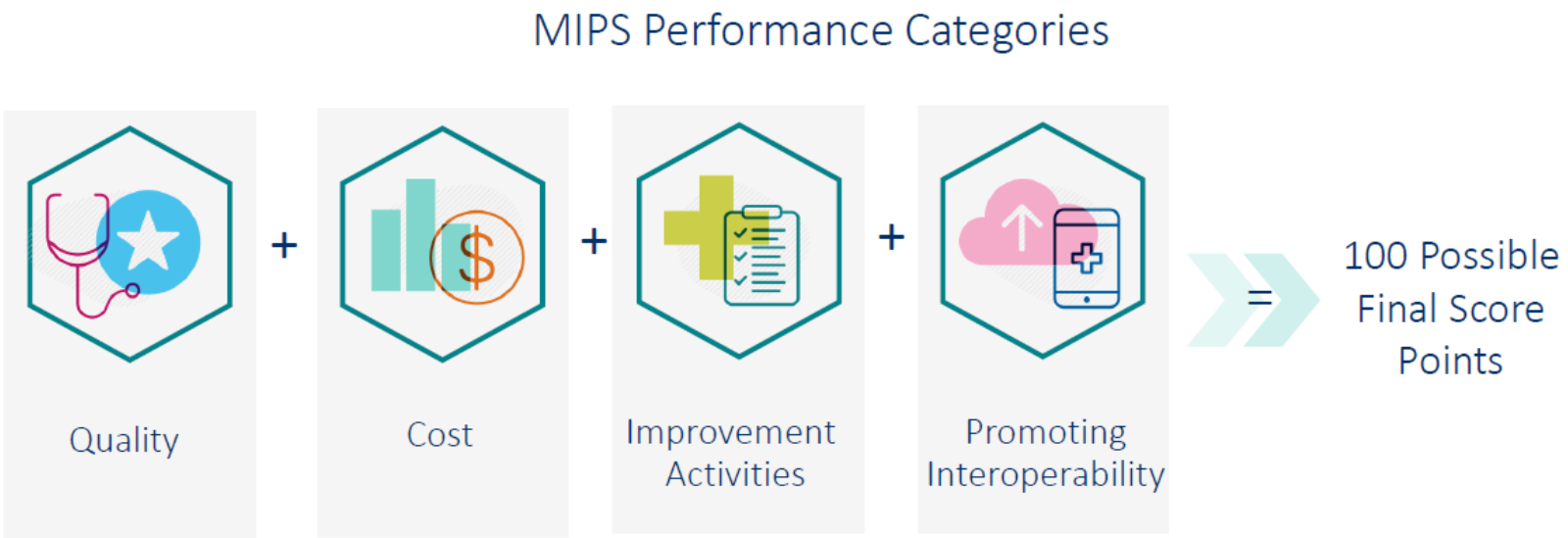
Background

- The four categories of the Quality Payment Program (QPP) are meant to complement each other.
  - They are not silos!
  - The legacy programs of the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program and the Value-based Payment Modifier did not connect.
  - It was not apparent that improving one legacy reporting program would affect another program.
  - The QPP has merged all of these legacy programs into one program to better link them for practice improvement.
  - QPP also reduces reporting burden on providers.

Legacy Programs into MIPS

Combined legacy programs into a single, improved program.

MIPS Performance Categories



Quality Payment Program

- Quality Performance Category
  - Measures to choose from: 275
  - Must report six measures, with one outcome or high-priority measure
  - May choose a specialty measure set
  - Measure submission by claims, registry, EHR or Web Interface
- Cost Performance Category
  - Two measures in 2018; adding episode-based measures in 2019
  - No reporting – calculated from administrative claims

Quality Payment Program

- Improvement Activities Performance Category
  - More than 100 improvement activities available
  - Goal is to link your improvement activities to make improvements in the other categories
- Promoting Interoperability Performance Category
  - Must use Certified Electronic Health Record Technology (CEHRT) to report (2015 Edition CEHRT for 2019)
  - May request an exception for certain circumstances

Synergies in the QPP

- Capitalizing on the synergies between the various activities and measures has a direct impact on patient-centered care
- The work of the QPP should
  - **Improve patient quality of care, cost of care and satisfaction**
  - **Improve workflow for the providers and practice staff**
- Reporting measures is not the goal!
  - **It is the end-result of your practice improvement efforts**

Example: Improving Diabetes Control

Improvement Activity ⇔ **Related Quality Measures**

- IA-PM-4: Glycemic Management Services (high weight)

Related Quality Measures

- Quality ID: 117 – Diabetes: Eye Exam
- Quality ID: 163 – Diabetes: Foot Exam
- Quality ID: 001 – Diabetes: HbA1c Poor Control (>9%)
- Quality ID: 119 – Diabetes: Medical Attention for Neuropathy

Example: Improving Patient Experience

Improvement Activity

- IA-PSPA-11: Participation in CAHPS or other supplemental questionnaire (high weight)

Related Quality Measures

- Quality ID: 321 – CAHPS for MIPS Clinician/Group Survey (high priority)
- Quality ID: 304 – Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery (high priority)

Example: PI and Quality Categories Within the Office Setting

PI Measures

- Patient-generated data
- Patient-specific education
- Provide patient access

Related Quality Measures

- Quality ID: 236 – Controlling High Blood Pressure (impact of self-reported BP at home)
- Quality ID: 373 – Hypertension: Improvement in Blood Pressure
- Quality ID: 288 – Dementia: Caregiver Education and Support
- Quality ID: 398 – Optimal Asthma Control (Uses patient-reported outcome tools [Outcome])

Example: PI and Quality Categories Across the Continuum of Care

PI Measures

- Clinical Information Reconciliation
- Send Summary of Care
- Request/Accept Summary of Care

Related Quality Measures

- Quality ID: 046 – Medication Reconciliation Post-Discharge (high priority)
- Quality ID: 458 – All-cause Hospital Readmission (outcome)
- Quality ID: 374 – Closing the Referral Loop: Receipt of Specialist Report (outcome)
- Quality ID: 130 – Documentation of Current Medications in the Medical Record (high priority)

Example: Improvement Activities to impact the PI Measures for Care Coordination

Improvement Activities

- Care transition standard operational improvements
- Care transition documentation practice improvements

PI Measures

- Clinical Information Reconciliation
- Send Summary of Care
- Request/Accept Summary of Care

Example: Improving Cost Measures

Related Quality Measures

- Quality ID: 458 – All-cause Hospital Readmission (outcome)
- Quality ID: 374 – Closing the Referral Loop: Receipt of Specialist Report (outcome)
- Quality ID: 130 – Documentation of Current Medications in the Medical Record (high priority)
- Quality ID: 046 – Medication Reconciliation Post-Discharge (high priority)

Medicare Spending Per Beneficiary (MSPB) Measure

The MSPB clinician measure determines what Medicare pays for services performed by an individual clinician during an MSPB episode—the period immediately before, during and after a patient's hospital stay.

Process of Improvement

- IHI Model for Improvement provides a guide for the improvement process.
- Begin with three questions:
  - What would you like to accomplish?
  - How will you know that the change made has been an improvement?
  - What changes will you make to accomplish this improvement?

Practice Improvement with the QPP

1. Select the Quality measures to report for that year of the QPP or that you plan to focus on for that year in your practice.
2. Obtain the base measures to plan your strategy.
   - Both Quality measures and Cost, if possible
3. Work with the entire practice team to identify current processes, potential improvements and responsibilities.
4. Identify related QPP measures and activities.
5. Prioritize your activities to have the most impact.
6. Obtain measurements monthly to monitor progress.

Working Across the Categories – Practice Setting

What data points are in decision-making for practice improvement?

Quality Measures	Promoting Interoperability	Improvement Activities	Cost
• Quality ID: 001 – Diabetes: HbA1c Poor Control (>9%) • Quality ID: 236 – Controlling High Blood Pressure	• Patient-generated data • Patient-specific education • Provide patient access	• Use of certified EHR to capture patient-reported outcomes • Measurement and improvement at the practice and panel levels	• Medicare Spending Per Beneficiary (MSPB) • Total Per Capita Costs (TPCC)

Available Data

Measure	Value
Diabetes: HbA1c Poor Control (>9%) – Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (inverse measure)	35%
Controlling High Blood Pressure – Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period (systolic and diastolic measured separately-must meet both values to count)	80%
Current enrollment in the patient portal	50%
Current enrolled portal patients actively using in the last year	15%
Cost measures – Obtain if possible from leadership	

- Which clinical measure would you focus on?
- How would you use the other QPP categories to improve that clinical measure?

Working Across the Categories – Care Coordination

Quality Measures	Promoting Interoperability	Improvement Activities	Cost
• Quality ID: 374 – Closing the Referral Loop: Receipt of Specialist Report • Quality ID: 046 – Medication Reconciliation Post-Discharge	Health Information Exchange • Send a Summary of Care • Request/Accept Summary of Care • Clinical Information Reconciliation	• Use decision-support and standardized treatment protocols to manage workflow in the team to meet patient needs • Care transition standard operational improvements • Care transition documentation practice improvements	• Medicare Spending Per Beneficiary (MSPB)

Available Data

Measure	Value
Closing the Referral Loop: Receipt of Specialist Report – Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	70%
Medication Reconciliation Post-Discharge – The percentage of discharges from any inpatient facility (e.g., hospital, skilled nursing facility or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is submitted as three rates stratified by age group: • Submission Criteria 1: 18–64 years of age • Submission Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older	1. 85% 2. 75% 3. 80%
Current Request/Accept Summary of Care	174/232
Current Clinical Information Reconciliation (for Transitions in Care)	405/512
Cost measures – obtain if possible from leadership	

Questions?

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Resources

- CMS Quality Payment Program website: https://qpp.cms.gov
- Review of QPP Measures: https://qpp.cms.gov/mips/explore-measures/improvement-activities?py=2018#measures
- QPP CME videos on Medicare Learning Network: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- TMF Learning and Action Network: https://www.tmfqin.org/Networks/Quality-Payment-Program
- How to Improve (2018). IHI: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Disclosures

- This material was prepared by TMF Health Quality Institute, the Quality Payment Program for Arkansas, Colorado, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, Puerto Rico and Texas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. TMF-QPPSURS-18-180

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