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Industry Report:
The State of QPP Preparedness

New research reveals that health systems relying on EHR and PHM systems for quality performance management are at risk of falling short of their goals of maximizing payment incentives.

## CONFLICTING ANSWERS REVEAL MISALIGNMENT OF GOALS AND REALITY

According to a new survey, the majority (64%) of healthcare providers intend to maximize payment incentives associated with the CMS Quality Payment Program (QPP). But with 97% of respondents relying on their electronic health record (EHR) or population health management (PHM) solution as their primary tool to do so, low satisfaction scores (39% average) indicate that these ambitious goals are at risk.

The study, conducted by Porter Research and sponsored by SA Ignite, surveyed nearly 120 medical, quality, and operations executives and directors, from large health systems and integrated delivery networks

about using EHR and PHM systems as the primary tool to manage performance in the QPP. Respondents indicated that they are very familiar with their organizations' QPP efforts, and the majority identified themselves as influencers or decision makers in managing performance in the program.

Three factors surfaced in the study that threaten the providers' ability to maximize QPP incentives using these tools, including lack of system preparedness, poor customer satisfaction rates, and limited focus on program complexities. This report reveals the research findings, and discusses the relationship to emerging trends in value-based program management. It offers practical guidance on what providers need to consider today to effectively manage performance and maximize payment incentives in the QPP, and other value-based programs, in the future.
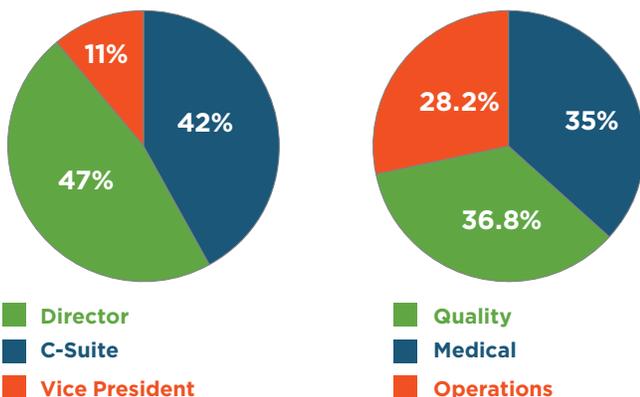
THE STAGE IS SET

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) passed with bi-partisan support. Under MACRA, CMS applied learnings from existing payment programs to design an umbrella Quality Payment Program (QPP) that combines Meaningful Use, PQRS, and the Value-based Modifier, and ends the Sustainable Growth Rate formula for Medicare Part B.

TITLE AND DEPARTMENT

■ Director	■ Quality
■ C-Suite	■ Medical
■ Vice President	■ Operations

The main goals of the QPP are to improve health outcomes, shift from volume-based to value-based care, spend wisely, and minimize the burden of participation. Two reimbursement paths under MACRA – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – are intended to give providers options for participation, and time to comply. According to the research, 94% of respondents are actively participating in the QPP, with 63% of respondents choosing to take the MIPS path and 31% choosing the APM path.

No matter which path providers choose, the fact is that value-based programs are rapidly expanding, and commercial payers are quickly following suit with their own forms of accountable care reimbursement models. Survey responders recognize this, with 80% stating that the QPP is part of a broader value-based initiative within their organizations.

> ## 80% believe the QPP is part of a broader value-based initiative within their organization

High participation rates along with the highly competitive nature of these programs are creating a new dynamic among health systems – one that requires a new way of thinking, a new culture of accountability across the organization, and new technology solutions that are specifically designed to handle the complexities of these rapidly evolving payment programs.

THE STATE OF PREPAREDNESS

Responses in this study reveal that healthcare providers are not in alignment organizationally, and don't have the right tools to achieve their self-stated goal of maximizing payment incentives in the QPP – and they may not even realize it yet.

Overwhelmingly, responses indicated the management of MIPS and APMs reside in the quality department (42%), however the rest (58%) were scattered across clinical, administrative, IT, and population health. There were a range of responses for the number of full-time resources organizations are utilizing to manage the QPP, with clusters around 1 person, 2 people, 5 people, and >10 people, indicating inconsistencies in organizational approaches to program management.
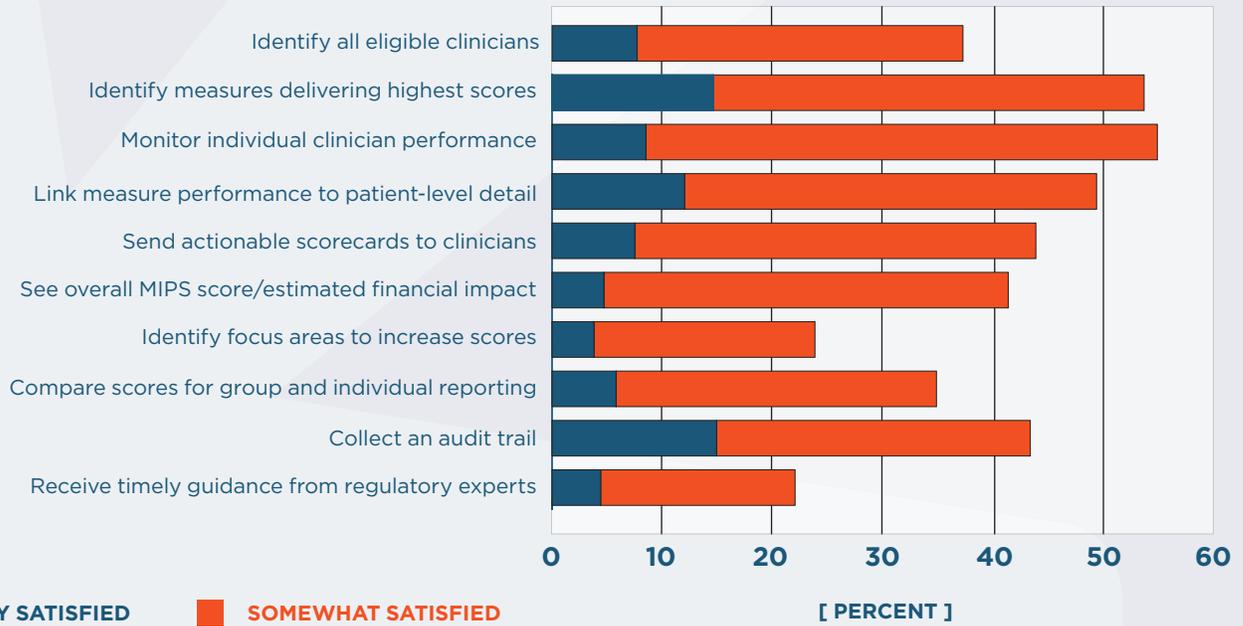
From a tools perspective, 83% stated that their EHR solutions are their primary method of managing QPP performance, yet 72% reported that their EHR vendor either doesn't offer a specific MIPS solution, or they don't know if the vendor offers a solution. For APMs, it was even worse, where 94% stated that their EHR vendor does not offer a solution today. PHM systems faired about the same, with 91% reporting no current MIPS solution and 79% reporting no current APM solution.

MISALIGNMENT OF SATISFACTION AND IMPORTANCE

Participants were asked to rate the importance of critical functionality to manage performance in MIPS or APMs, along with their satisfaction for leading EHR and PHM vendors, and there is a significant shortfall. The average satisfaction level across capabilities was 38%, ranging from a low of 18.8% to a high of 53.2%. For those who ranked each functional area as important or very important, the satisfaction levels dropped even more. For example, respondents who are very satisfied with the ability to see an overall MIPS score and estimated financial impact in the EHR is only 4.7%. Their satisfaction with the ability to improve that score is worse at

SATISFACTION WITH QPP CAPABILITIES IN THE EHR

[RATED 4 OR 5 ON A 5 POINT IMPORTANCE SCALE]

Identify all eligible clinicians
Identify measures delivering highest scores
Monitor individual clinician performance
Link measure performance to patient-level detail
Send actionable scorecards to clinicians
See overall MIPS score/estimated financial impact
Identify focus areas to increase scores
Compare scores for group and individual reporting
Collect an audit trail
Receive timely guidance from regulatory experts

0   10   20   30   40   50   60

■ VERY SATISFIED   ■ SOMEWHAT SATISFIED   [PERCENT]

3.8%. In addition, respondents are unsatisfied with the level of guidance and exposure to regulatory experts that they have through their EHR vendors. Only 4.4% are very satisfied and another 17.6% are somewhat satisfied, leaving 78% of the respondents who ranked guidance and expertise as important unsatisfied. The figure above shows the satisfaction levels across all of the key elements that were rated as important.

This misalignment between satisfaction and performance on capabilities that are deemed high importance demonstrates the risk that many organizations are facing today.

THE HIDDEN COMPLEXITIES

The significant gaps between what is important and what EHR and PHM vendors are providing should be no surprise. These systems are not intended to manage clinician data and perform the type of program management and detailed analysis required to optimize performance in a value-based program. They are designed to manage patient care and analyze population outcomes.

The rules governing MIPS, advanced APMs, and other value-based payment programs are complex, which makes program management a challenge from both a system and resource perspective. For example, based on the program rules, reporting as a group versus individual may impact scores and financial reimbursement, yet 70.9% of respondents said they are not satisfied with their EHR/PHM's ability to assist with this. In addition, CMS audits results, which may potentially reduce reimbursements or increase penalties, but only 9.4% of respondents are very satisfied with their EHR or PHM's audit documentation capabilities, leaving organizations at risk.

Further, when calculating the Quality score under MIPS, certain inverse measures prefer a lower score, which if not properly singled out, will not accurately reflect what the overall score will be. There are certain rules and exclusions that vary from year-to-year, and program-to-program, including data completeness, reporting periods, type of clinician, or whether they are hospital-based, to name a few.

These types of complexities can easily go undetected by vendors that don't specialize in understanding the intricate details of the rules, or focus on building capabilities that deliver the scenario analysis necessary to optimize performance. A vast majority, 81% of respondents, are not satisfied with the level of access to regulatory expertise from their EHR and PHM vendors.

Maximizing performance in value-based programs goes way beyond submitting the required data to CMS or other organizations. It requires the ability to dive into performance data by entity and clinician, look at trends over time, understand financial impact, and ultimately communicate effectively with clinicians who are bearing the brunt of this new way of working.

> Preparedness is at risk: 64% of respondents want to maximize payment incentives, yet 72% - 91% report their EHR or PHM does not currently offer a MIPS solution

ALIGNING FOR SUCCESS

For those organizations who want to focus efforts in quality performance improvement, outperform peers, and position themselves to capture the highest amount of incentives, here are five pieces of practical advice for improving your chances of success:

- **Know who to measure.** Eligibility changes year over year, and as clinician rosters change throughout the year there may be reporting requirements or options that are not on your radar. Having the ability to scope out scenarios, or compare results at an individual and group level, is one way healthcare organizations can optimize performance.

- **Know what to measure and how to report.** With 13 ACI measures, 200+ quality measures, and 40 IA measures for the 2017 performance year, each with different weights, benchmarks, and exclusions, it is challenging for organizations to know which measures will have the biggest impact. Having the right tools in place to identify hidden opportunities, predict scores, proactively address shortcomings, and select the optimal reporting method is a must.

- **Know who is responsible for what.** Transitioning to value-based care requires significant organizational and cultural changes to take place. Expertise in the measurement and reporting for MIPS, APMs, and other value-based programs is hard to find, and every EHR and PHM is different. A purpose-built solution for value-based program management mitigates the complexity, provides focus on meaningful activities, and mobilizes resources faster.

- **Know your own capabilities.** With value-based care programs set to expand over the next several years, providers must determine what is possible and practical for their specific organization. It is important to set realistic goals based on realistic plans. Having systems in place that are nimble and allow you to proactively build what-if scenarios based on your specific situation will be key to navigating what is possible for your specific organization.

- **Create a multi-year plan.** QPP and incentive-based payment models are here to stay, but that doesn't mean that they will stay the same. In fact, the AMA recently submitted a letter to CMS, urging officials to continuously receive feedback and analyze data while finding new ways to simplify the regulations and further streamline the program. Having a multi-year plan supported by predictive analytics tools specialized in regulatory compliance will give healthcare leaders fact-based insights to achieve their goals and better chart their own financial outcomes.

THE IMPORTANT CHOICE

MACRA was passed with bi-partisan support in the U.S. Congress, and the programs in the QPP were built on the learnings from existing value-based programs. Individual states and commercial payers are using these programs as a model for managed care contracts and additional value-based payment programs.

The results of the study indicate that healthcare organizations recognize the opportunity to excel, and be rewarded for above-average performance with aggressive goals, but unfortunately, many will be unprepared and ill-equipped with the right tools they need to succeed. While EHR and PHM systems may have been good enough for the early years of exploratory accountable care models, these systems are not prepared to help providers reach their goals of maximizing payment incentives and improving margins in competitive programs like MIPS and advanced APMs. To compete effectively in the value-based care environment, healthcare leaders should look to purpose-built solutions that mitigate the complexities of the rules and instead facilitate proactive program management.

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About SA Ignite. SA Ignite provides a compliance management and predictive analytics platform that simplifies the complexities of evolving value-based initiatives, optimizing quality scores through actionable insights that help healthcare organizations improve revenue and reputation.

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