INDIAN HEALTH SERVICE

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ANALYSIS

GPRA and GPRAMA Performance Reporting and CMS Clinical Quality Management Processes

ANALYSIS OVERVIEW AND PURPOSE

This analysis addresses the request by the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) to provide a comparison of the Government Performance and Results Act (GPRA) and later modified as the Government Performance and Results Act Modernization Act (GPRAMA) and the Centers for Medicare & Medicaid Services (CMS) clinical quality management approaches. The TSGAC requests this analysis to assess whether the IHS and Tribes should be aligning their quality assurance with the CMS approaches particularly since there might be economic consequences with regard to revenue from these important sources of payment for services. In response, this analysis provides an overview of IHS clinical quality reporting as of early 2016 and identifies key differences in reporting for GPRA/GPRAMA and CMS quality purposes.

This analysis is divided into four sections:

- **Section 1** provides an overview of the IHS Resource and Patient Management System and highlights two software applications that impact clinical performance measure reporting - the Electronic Health Record (EHR) and the Clinical Reporting System.
- **Section 2** provides an overview of the GPRA/GPRAMA law and its requirements.
- **Section 3** includes a brief overview of the CMS clinical quality approaches including: the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the EHR Incentive Program for Eligible Providers (EPs), commonly referred to as Meaningful Use (MU).
- **Section 4** discusses the future of clinical quality reporting requirements for Medicare.

In general, the analysis provides an overview of how IHS addresses the reporting requirements as required by law. However, it should be noted that individual sites and Areas might have other processes or requirements than those discussed in this document.

A summary table of the law and quality participation reporting requirements is included along with information about the purpose, timeline, type of data collected, and estimated cost of data collection. Additionally, a table of IHS clinical GPRA/GPRAMA measures and IHS clinical quality measures as reported to CMS is included for TSGAC reference and review.

SECTION 2:
GPRA/GPRAMA OVERVIEW

The purpose of the Government and Performance Results Act (GPRA) enacted August 3, 1993 is to improve the efficiency and effectiveness of Federal programs by establishing a system to set goals for program performance and to measure results. These requirements included reporting performance plans in the President's Budget, preparing annual performance plans in the budget, and annual reporting on program performance to the President and Congress for the previous fiscal year for performance measures, actual performance results, and a comparison with plan goals for that fiscal year. The goal-setting, performance measurement and results reporting requirements were intended to address the needs of Congress and federal program managers. GPRA implementation included a four-year phase-in period and 13 years of full implementation. The IHS prepared for GPRA performance reporting in conjunction with the IHS budget formulation process and formally began reporting GPRA measures in 1997 for the FY 1999 budget. Annually, IHS GPRA performance results and targets are reported in the President's Budget request.

The GPRA Modernization Act of 2010 (GPRAMA), modified the 1993 GPRA law. Among several changes, GPRAMA aligns the timing of many performance products to coincide with presidential terms and budget proposals. GPRAMA requires continued use of performance products required under the GPRA including: a four-year Agency Strategic Plan (Note: Agency refers to federal executive departments such as the Department of Health and Human Services), annual Agency Performance Plan, and an annual Performance Update. GPRAMA adds new requirements for goal-setting, implementation reviews and plans and reports, including: Agency Priority Goals (APGs), Quarterly review of APGs, and an Office of Management and Budget Performance website. IHS reports performance results in accordance with the requirements established by the United States Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB). IHS contributes several measures to the HHS Annual Performance Plan and Report.

IHS GPRA/GPRAMA Measures

Since 2005, IHS has developed and reported GPRA/GPRAMA measures from the CRS (as previously discussed a module within the RPMS, the IHS EHR. Measures are developed by "measure owners" (e.g. Subject Matter Experts, including clinicians) who work with the CRS team to establish the logic needed for the measure. The results are aggregated from the facility to the Area to the National level. Clinical measure denominators include the IHS active clinical population or user population. As such, the GPRA/GPRAMA clinical measures might not completely align to national quality measures established for the national health care system, in general.

As stated previously, IHS measures are reported in the annual President's Budget request and are developed consistent with the budget process. In accordance with the budget policy and procedures, IHS is required to ensure the completeness, reliability, and quality (verification and validation) of the performance data reported. Measures are reported according to the IHS budget and the GPRA year (July 1-June 30 for CRS), the FY 2015 GPRA year includes reporting of 23 clinical measures (see Table 2).

SECTION 3:

CMS CLINICAL QUALITY MEASURES (CQMs)

Over the past decade, the Centers for Medicare & Medicaid Services (CMS) has implemented the use of Clinical Quality Measures (or CQMs). CQMs are tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals within the United States health care system.

The measures use data associated with an individual provider's ability to deliver high-quality care or relate to long term goals for quality health care and assess different aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, population and public health and adherence to clinical guidelines. According to the CMS website, reporting on these measures helps ensure the health care system is delivering effective, safe, efficient, patient-centered, equitable and timely care.

In addition to these programs, other Medicaid program reporting requirements might be required by the States. HHS publishes core set of measures for adults and children's health for voluntary use by State Medicaid and CHIP programs.

CMS Measure Development Process

CMS has developed a standardized approach, the Measure Management System (MMS), for the development and maintenance of the quality measures used in its various quality initiatives and programs. The system is composed of a set of business processes and decision criteria that CMS funded measure developers (or contractors) follow in the development, implementation, and maintenance of quality measures. Measures developed using the MMS have been found to meet the high standards required by the National Quality Forum (NQF) for consensus endorsement. The NQF reviews, endorses and recommends use of standardized health care performance measures.

According to the CMS MMS Blueprint version 11.2, the time it takes from measure conceptualization to measure implementation is anywhere from 1-27 months. Measure use, continuing evaluation and maintenance is 27 months and beyond. Measures undergo public comment periods, feasibility, alpha and beta testing, NQF endorsement, and are regulated by the federal rulemaking process.

As required by law, the CMS has instituted several quality measurement and reporting programs for Medicare, including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Record (EHR) Incentive Program for Eligible Providers (EPs), commonly referred to as Meaningful Use (MU).

IHS CQM Reporting

To fulfill reporting requirements for CMS CQM reporting, IHS is implementing the Clinical Quality Measure system in RPMS. The CQM technology platform provides tools to support the CMS EHR incentive program for stage 2 MU. The CQM application maps to workflows for problem/diagnosis search, and synchronization of term-to-code maps between clinical information systems. CQM measures are selected by professionals across the I/T/U community for the menu set defined and prescribed by CMS.

SECTION 3:

CMS CLINICAL QUALITY MEASURES (CQMs) (continued)

Value Modifier (VM) / Physician Quality Reporting System (PQRS)

The Patient Protection and Affordable Care Act, section 3007, mandated that by 2015, CMS apply a value modifier (VM) under the Medicare Physician Fee Schedule (MPFS). The VM is an adjustment made on a per-claim basis to Medicare payments for items and services under the Medicare Physician Fee Schedule (MPFS) and is to be phased in based on the size of the physician group, as well as transitioning to include individual physicians. The VM provides a differential payment under the MPFS, based on prior performance (quality of care furnished compared with the cost of care).

Under Value Modifier/PQRS reporting, IHS RPMS sites have the opportunity to report PQRS measures on an annual basis. Due to the amount of manual effort that is required to extract data from RPMS, some sites have difficulty reporting PQRS performance measures and as of January 2016, if PQRS measures are not reported, a PQRS negative adjustment will be applied (2%) to Physician Fee Schedule Payments (Part B). There may also be a negative adjustment due to Value Based Modifier. Implementation of the PQRS system will ease, if not alleviate manual reporting adjustments to fee payments accordingly. To date, a few IHS sites are reporting PQRS measures via a Registry or via a Web Interface (if a GPRO).

Meaningful Use (MU) and Electronic Health Records (EHR)

As information technology (IT) and access to information became an increasingly large part of American culture and business, including healthcare, Congress passed legislation to smooth the transition for the creation, control, and dissemination of electronic medical information. The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health IT by eligible providers (EP) and eligible hospitals (EH) including critical access hospitals.

The legislation required the HHS to establish programs to incentivize the adoption and meaningful use of health IT. The HITECH Act called for the establishment of provider incentive payments to EPs who meaningfully use EHR technology, including quality measures derived from EHRs. Beginning in 2015, EPs who do not meet the requirements of the EHR Incentive Program and who do not qualify for a hardship exception received a downward payment adjustment.

MU and EHR reporting consists of addressing the Office of the National Coordinator for Health Information Technology (ONC) and CMS objectives to encourage electronic health record adoption. Health care providers are required to utilize a certificated EHR. Typically there are a minimum number of required measures but the requirements can vary as dictated. For 2015, IHS is reporting on 34 certified measures (18 certified eligibility professional and 16 electronic health record), and 6 additional measures require updates to annual CRS measures (see Tables 3 and 4).

CONCLUSION

This analysis provides an overview of IHS reporting for GPRA/GPRAMA and several CMS clinical quality programs and highlights several key differences in the reporting purpose, the processes for measure development and the future reporting requirements for Medicare. With the implementation of MACRA, there might be opportunities to align measures however, the purpose and quality of reporting for various purposes will need to be considered.

The purpose of IHS clinical GPRA/GPRAMA measures are to track IHS clinical activities on important health indicators and to support the IHS budget a very different purpose than submitting data for CMS reimbursement for eligible professionals, eligible hospitals and critical access hospitals. Table 1 is a measure summary including the reporting purpose, timeline, types of data collected and the estimated costs for GPRA/GPRAMA and the national quality initiatives. The GPRA/GPRAMA measures serve as the Agency's monitoring of key clinical activities that are important to track and provide health care for the American Indian and Alaska Native (AI/AN) population and this information is reported to Congress. Although IHS programs and reports several clinical quality measures for CMS reimbursement, the CMS measures are not tracked or reported nationally for the IHS. The primary difference of GPRA/GPRAMA versus CMS clinical quality reporting is the intent of reporting and determining which measures are needed to track population health versus which measures can feasibly be reported for multiple clinical reporting requirements including reimbursement by eligible professionals, eligible hospitals and critical access hospitals.

The difference in reporting purposes might also explain why the current measure reporting cycle differs for the CMS quality initiatives and the GPRA/GPRAMA measures. The GPRA/GPRAMA measures are developed for the purpose of monitoring IHS patient health and measures are tracked, reviewed, monitored and updated at least three times during the year on a national basis or as needed based on the recommendations of measure owners who use the data to provide care. And, measures are reported annually in the President's Budget. The clinical quality measures reported to CMS are to measure and track national priorities as determined by CMS after a lengthy measure development process. The length of time it takes to develop and implement measures for CMS MMS purposes (up to 27 months) contrasts the relatively quick process (measures reviewed every 6 months) for the IHS GPRA/GPRAMA measures.

IHS reports a GPRA/GPRAMA measure for the Million Hearts® national quality initiative, where alignment is appropriate. Under MACRA there might be opportunities to align clinical measures however, it is too early to identify appropriate measures since the CMS is still developing guidelines for implementation including which measures will be reported for Medicare reimbursement purposes. Accordingly, IHS will continue to fulfill the GPRA/GPRAMA reporting requirements, develop the IDCS DM, and monitor MACRA developments. Moving forward, the Agency will need to assess the pros and cons of dual reporting for GPRA/GPRAMA and national quality initiatives and decide if there is a positive benefit in using national quality measures to track AI/AN patient care for the services provided by IHS.

Table 2. IHS GPRA/GPRAMA clinical measures (identified for CRS 15.1)

Results are reported at the National-level (for the AI/AN patient population) to Congress

Measure Type	Diabetes	Immunizations	Behavioral Health	Cardiovascular Disease	Dental	Cancer	STD	Other Clinical Group
GPRAMA: The following are the official GPRAMA measure reported in the National GPRA Report submitted to the Office of Management and Budget (OMB) and Congress, and included in the annual HHS Online Performance Appendix for CRS Version 15.1	Glycemic Control [CRS: 2.1.2.4.4]	Childhood Immunizations [CRS: 2.3.3.4.1]	Depression Screening or Mood Disorder [CRS: 2.5.3.4.1]	Comprehensive CVD-Related Assessment [CRS: 2.6.3.4.6]				
GPRA: The following are the official GPRA measure reported in the National GPRA Report submitted to Office of Management and Budget (OMB) and Congress in the annual IHS budget process for CRS Version 15.1.	Blood Pressure Control [CRS: 2.1.3.4.2] LDL Assessment [CRS: 2.1.4.4.1], Nephropathy Assessment [CRS: 2.1.5.4.1], Diabetic Retinopathy Assessment [CRS: 2.1.6.4.1]	Influenza [CRS: 2.3.1.4.1], Adult Immunizations: Pneumococcal Vaccine [CRS: 2.3.2.4.1]	Alcohol Screening (Fetal Alcohol Syndrome Prevention) [CRS: 2.5.1.4.1], Intimate Partner (Domestic) Violence Screening [CRS 2.5.2.4.1]	Childhood Weight Control [CRS: 2.6.1.4.1], Controlling High Blood Pressure – Million Hearts [CRS: 2.6.2.4.1]	Access to Dental Services [CRS: 2.2.1.4.1], Dental Sealants [CRS: 2.2.2.4.1], Topical Fluoride [CRS: 2.2.3.4.1]	Screening: Pap Smear Rates [CRS: 2.4.1.4.1], Screening: Mammogram Rates [CRS 2.4.2.4.1], Colorectal Cancer Screening [CRS 2.4.3.4.1], Tobacco Cessation [CRS: 2.4.5.4.3]	Prenatal HIV Screening [CRS: 2.7.1.4.1]	Breastfeeding Rates [CRS: 2.8.1.4.6]
Supplemental Measures: The following are the measures that are not official GPRA measures, but is included in the National GPRA Report provided to OMB and Congress to provide context to a GPRA measure(s).	Diabetes Prevalence - Diabetes Diagnosis Ever [2.1.1.4.1], Glycemic Control - Documented HgbA1c [CRS: 2.1.2.4.1]							
Non Official : The following are the measures that are not an official GPRA measures and are not included in the National GPRA Report provided to OMB and Congress. These measures provide context to GPRA measure(s).	Diabetes Prevalence - Diabetes Diagnosis during Report Year [CRS: 2.1.1.4.2], Diabetes - Blood Pressure Assessed [2.1.3.4.1]	Childhood Immunizations - 4 doses of DTaP vaccine [CRS: 2.3.3.4.2], Childhood Immunizations - 4 doses of Pneumococcal conjugate vaccine [CRS: 2.3.3.4.8], Adult Immunizations - Pneumococcal vaccine any time before the end of Report Period [CRS: 2.3.2.4.2]				Tobacco Screening - Tobacco Assessment [CRS: 2.4.4.4.1], Tobacco Screening - Tobacco Users [CRS: 2.4.4.4.2]		

Certified Measure	Eligible Hospital (EH)	Measure Title
CMS91v4	EH	S: Thrombolytic Therapy
CMS104v3	EH	S: Discharged on Antithrombotic Therapy
CMS107v3	EH	S: Stroke Education
CMS73v3	EH	VTE: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
CMS110v3	EH	VTE: Venous Thromboembolism Discharge Instructions
CMS30v4	EH	AMI: Statin Prescribed at Discharge
CMS60v3	EH	AMI: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
CMS31v3	EH	Peds: Hearing Screening Prior To Hospital Discharge
CMS9v3	EH	Peds: Exclusive Breast Milk Feeding
CMS26v2	EH	Peds: Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
CMS 185v3	EH	Peds: Healthy Term Newborn

Table 4. IHS CQM Requiring Certification and Update
Results are reported by Eligible Provider or Eligible Hospital to CMS

Measures that need to be Certified	EP	Measure Title
CMS122v3	EP	Diabetes: Hemoglobin A1c Poor Control
CMS123v3	EP	Diabetes: Foot Exam
CMS131v3	EP	Diabetes: Eye Exam
CMS134v3	EP	Diabetes: Urine Protein Screening
CMS148v3	EP	Hemoglobin A1c Test for Pediatric Patients
CMS163v3	EP	Diabetes: Low Density Lipoprotein (LDL) Management