Georgia Clinical Quality Measures
Project Overview

• Implement and operationalize an effective way to accept clinical quality measurement information from providers across multiple channels to support program goals.

- Track the quality of health care services
- Ensure delivery of effective, safe, efficient, patient-centered, equitable, and timely care
- Use data associated with a provider’s delivery of health care
- Use established clinical measures
- Align with other agencies for health care quality improvement

• Assess trends against various benchmarks (e.g. member/disease categories, specific provider geographies or subsets of provider types).

• Through a phased approach, gain insight and lessons learned for an effective roll-out to a larger community.
National CMS Strategic Direction

CMS Authorized Programs

- National programs due to the Affordable Care Act (ACA), the Medicare Access and CHIP Reauthorization Act (MACRA), the Merit-Based Incentive Payment System (MIPS) – all focusing on moving from Volume, or Fee-for-Service, to Value, or Outcomes-based Medicine.

- Quality Measures based on claims and electronic health record data make up the core of these programs, and are being used to assess program efficacy and patient population health.

- Data collection across multiple providers will be compared to benchmark data at state and national level, and then eventually factored into financial models.
Your Participation

What we are implementing?
A unified platform with capability for accepting data across multiple channels, performing rules-driven analysis, and reporting on an initial set of targeted quality measures. Or simply put, a website for upload/entry of metrics and related reporting.

What we will provide:
• Training to leverage certified EHR system capabilities and, when necessary, minimal entry of CQM data.
• Full transparency to the provider’s information via reports and project team updates.
• Support of a Clinical Advisory Board (CAB) to offer clinical assistance, measure selection, recommendations on use of data, reports, and collaborative support with the DCH and provider participants in shaping the program.

Why we hope you will participate:
• Influence future efforts on how this information is collected.
• Represent a provider “voice” to the project’s efforts and goals.
• Gain your feedback on application/program effectiveness and any limitations.
What Your Participation Looks Like

• MAPIR data captured for state average calculation. No action required beyond what already occurs through data upload to the MAPIR application for those who participate in the Medicaid EHR Incentive Program.
• Quarterly CQM data upload via EHR application (QRDA III format) or manual data collection.
• We will provide reports related to the data you submit and comparison information against planned benchmarks.
• Collection of your feedback.

Provider Community

Today

Future

✓ Upload CQM data via EHR
✓ Manual entry of CQM *(if needed)*
✓ Access to Reports
CQMS Project Benefits

• Alignment with CMS direction and efforts supporting improved health outcomes.
• Development and use of a platform from which the Department can perform consistent, rules-driven evaluation of effectiveness for value-based purchasing outcomes, improving health outcomes and inform providers on performance compared to peers/state norms.
• Improved health outcomes for Medicaid members through the effective use and comparison of provider-generated data.
• Increased insight into provider’s level of quality and efficiency of care through benchmarking and quality initiatives.
• Ability to manage and proactively control Medicaid programmatic goals through reporting tools and benchmarking capabilities.

Three goals for our healthcare system:
• BETTER care
• SMATER spending
• HEALTHIER people

Via a focus on two areas:
• Care Delivery
• Information Sharing
Seven “CQMs” for GA CQMS

The initial measures planned for the project include:

1. CMS2 - Preventative Care and Screening for Depression
2. CMS69 - Preventive Care and Screening: BMI screening and follow up plan (ages 18 and older)
3. CMS122 - Diabetes: Hemoglobin A1c poor control (>9%) (ages 18-75)
4. CMS125 - Breast Cancer Screening
5. CMS 126 - Use of Appropriate Medications for Asthma (ages 5-64)
6. CMS165 - Controlling High Blood Pressure
7. CMS153 - Chlamydia Screening for Women (ages 16-24)
CMS ID 2: Preventive Care and Screening Depression
CMS ID 79: Preventive Care and Screening BMI
CMS ID 122: Diabetes Hemoglobin A1c Poor Control
CMS ID 123: Breast Cancer Screening
CMS ID 126: Use of Appropriate Medications for Asthma
CMS ID 153: Chlamydia Screening for Women
CMS ID 165: Controlling High Blood Pressure
Next Steps

- We need your participation
- Schedule a follow-up discussion with project Executive Sponsors
- Arrange for access to the CQMS application, timeline for data collection, reporting and review

- *Future program plans/considerations:*
  - Additional CQMs
  - Geocoding of population health data
  - Expanded reporting
  - …and more!