Health Care Reform 2014: a Practice Based Approach

Southwestern Conference on Medicine

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Agenda

- Physician Value Based Purchasing
  - Overall strategy
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VM)
  - Electronic Health Record (EHR) Incentive Programs
- Fraud and Abuse Update

Strategy

The strategy is to concurrently pursue three aims

Better Care	**Improve overall quality by making health care more patient-centered, reliable, accessible, and safe**
Healthy People/Healthy Communities	**Improve population health by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care**
Affordable Care	**Reduce the cost of health care for individuals, families, employers, and government**

Value-Based Purchasing Program Objectives over Time Towards Attainment of the Three-Part Aim

Initial programs FY2012-2013

- Limited to hospitals and dialysis facilities
- Existing measures providers recognize and understand
- Focus on provider awareness, participation, and engagement

Near-term programs FY2014-2016

- Expand to include physicians
- New measures to address HHS priorities
- Increase emphasis on patient experience, cost, and clinical outcomes
- Increase provider engagement to drive quality improvements, e.g., learning and action networks

Longer-term FY2017+

- Measures and incentives aligned across multiple settings of care and at various levels of aggregation
- Measures are patient-centered and outcome oriented
- Measure set addresses all 6 national priorities well
- Rapid cycle measure development and implementation
- Continued support of QI and engagement of clinical community and patients
- Greater share of payment linked to quality

Vision for VBP

Physician Quality Reporting System and the Value Modifier

PQRS Overview

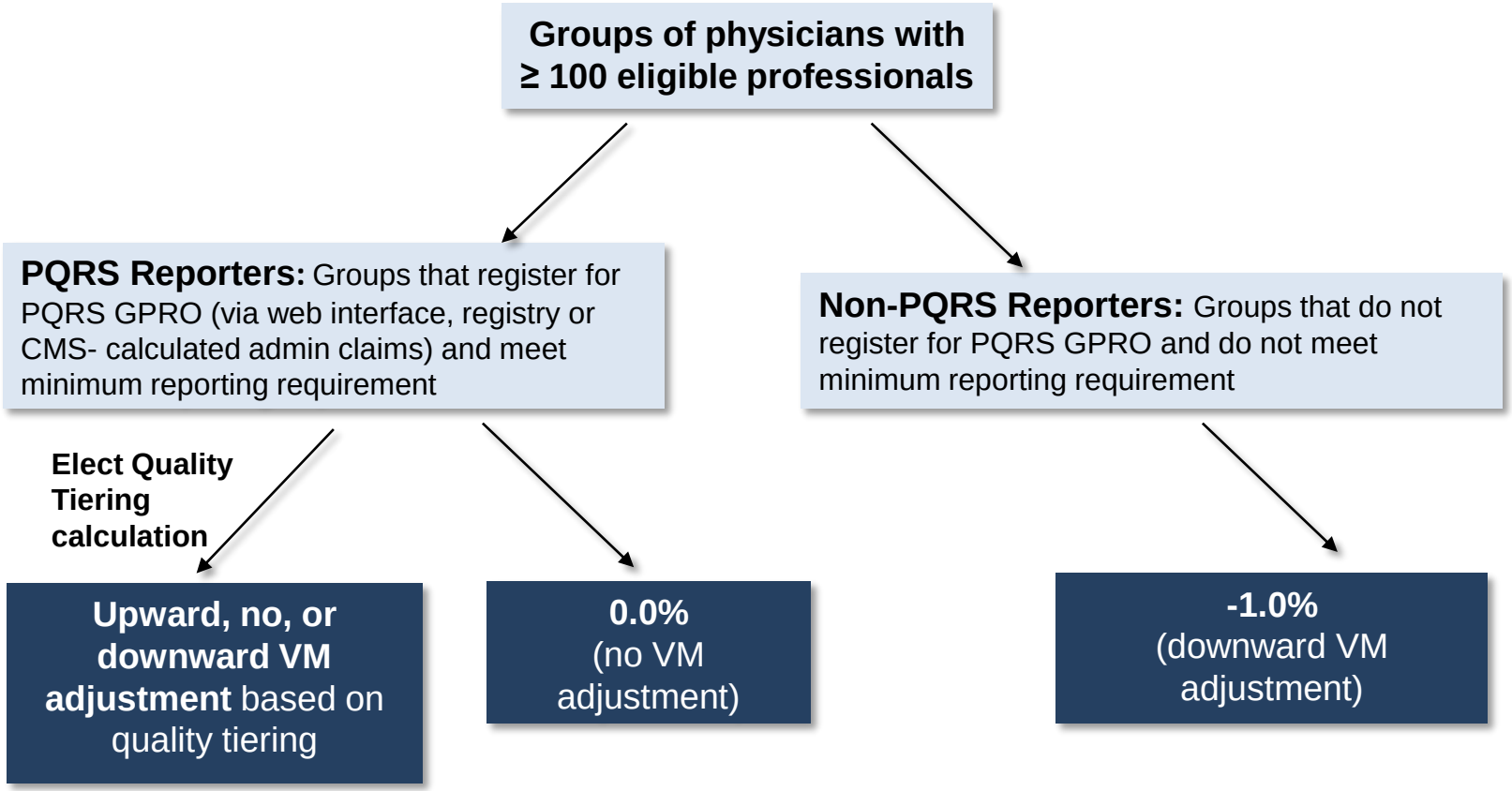
- Reporting program began in 2007
- Eligible Professionals (EPs) or group practices who satisfactorily report quality data earn an 0.5% incentive payment for CY 2012 - 2014
- Additional 0.5% for the Maintenance of Certification Program Incentive, if applicable
- 2014 – Last year for incentive
- 2015 – Payment adjustment of -1.5% based on CY2013 participation
- 2016 - Payment adjustment of -2.0% based on CY2014 participation

Value-Based Payment Modifier (VM) Overview

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
- Begin phase-in of VM in 2015, phase-in complete by 2017
  - 2015 - VM applies to physician payment for groups with ≥100 EPs
  - 2016 - VM applies to physician payment for groups with ≥10 EPs
  - 2017 – VM applied to all, or nearly all, physician payments
- Based on participation in PQRS

Value Modifier and Physician Quality Reporting System Are Linked, 2015

VM implementation in 2015 is based on PQRS participation in 2013



Reporting is a necessary first step towards improving quality.

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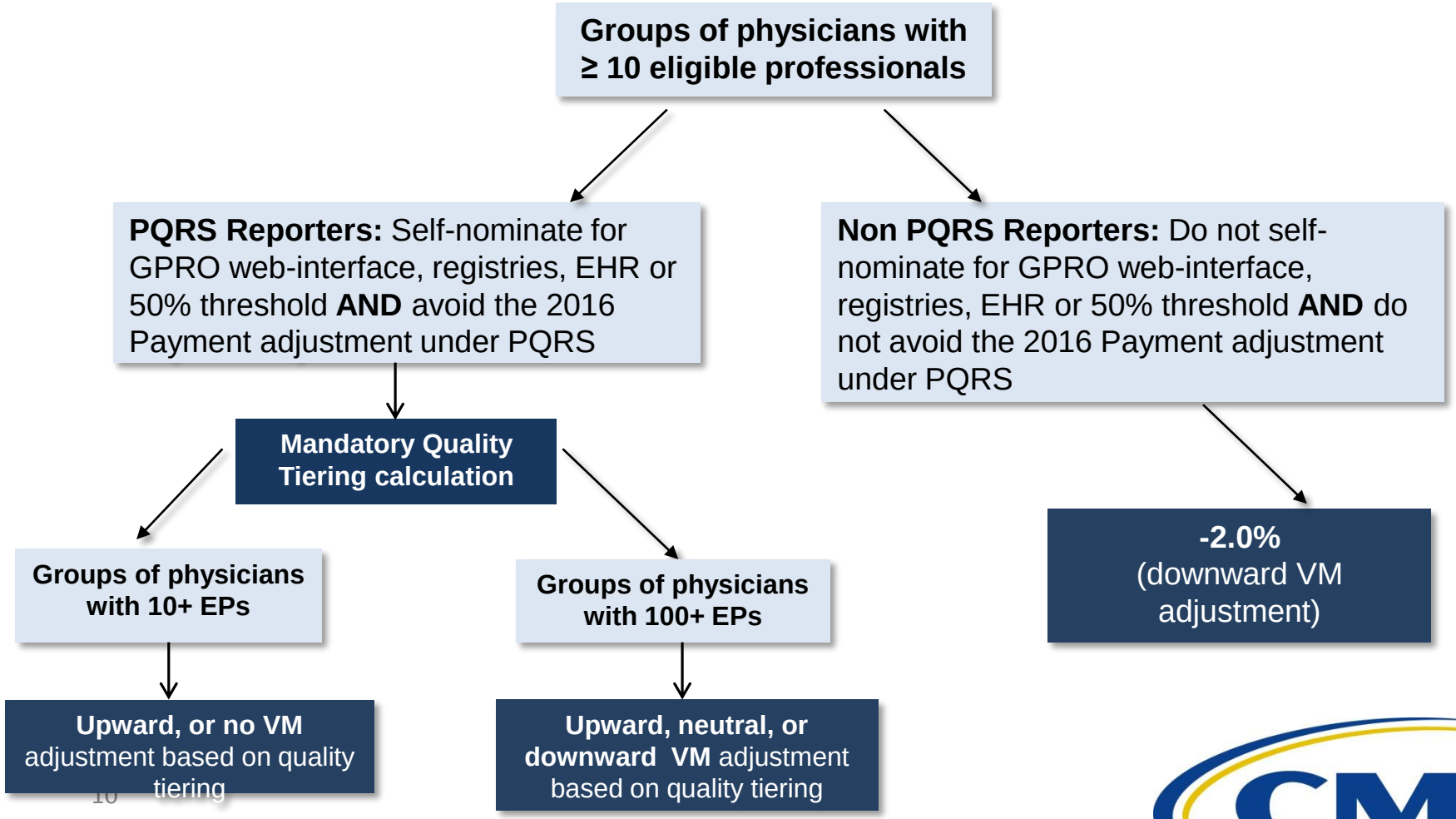

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What Quality Measures will be Used for Quality Tiering?

- Measures reported through GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 50% of the eligible professionals within the group
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)
- PQRS CAHPS Measures for 2014 (Optional)
  - Patient Experience of Care measures
  - For groups of 25 or more eligible professio

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What Cost Measures will be used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary measure: 3 days prior and 30 days after an inpatient hospitalization (attributed to group providing plurality of Part B services during hospitalization)
- All cost measures are payment standardized and risk adjusted
- Each group's cost measures adjusted for specialty mix of EPs

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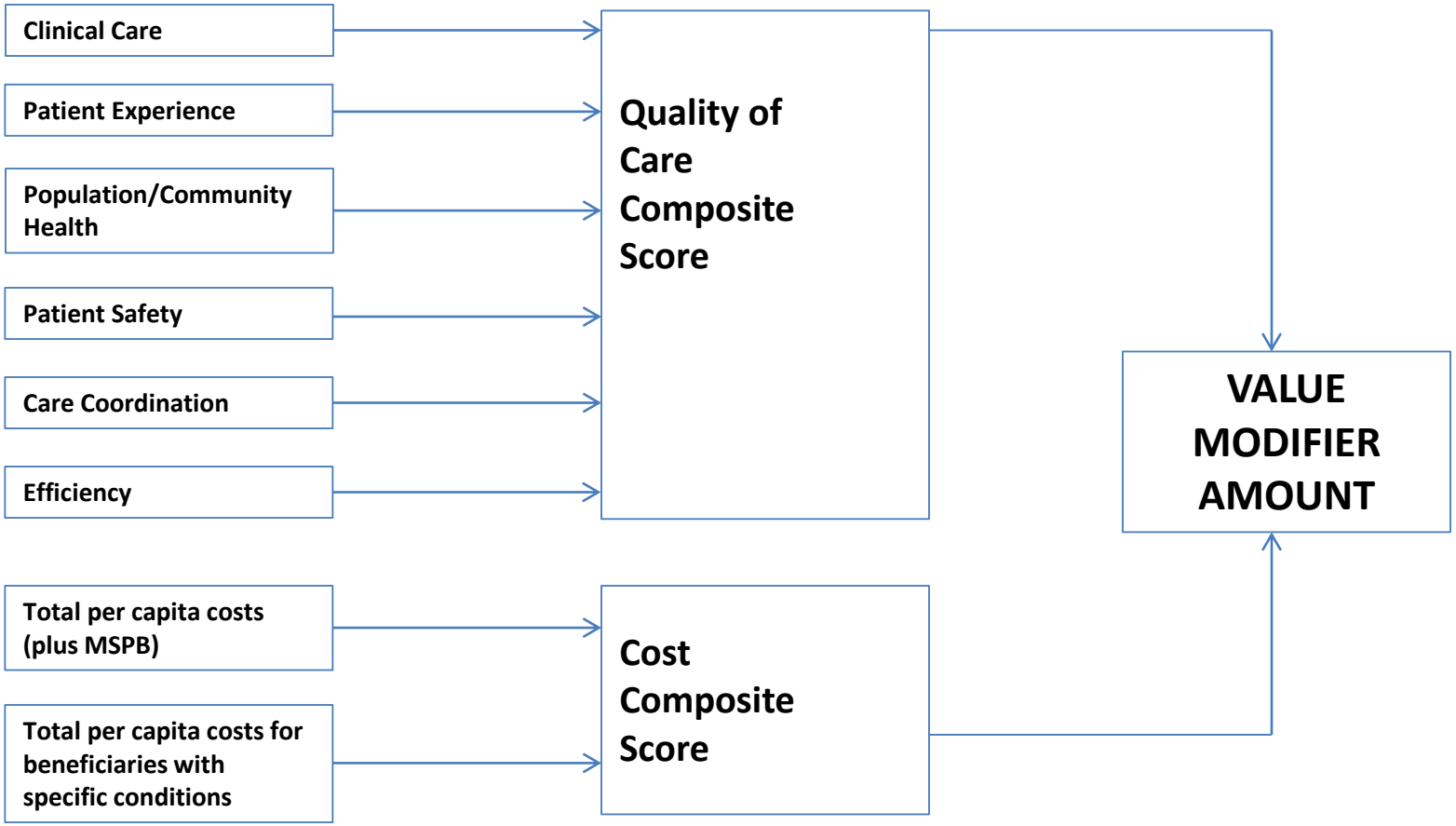
Quality-Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



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Quality-Tiering Approach

- **Each group receives two composite scores (quality of care; cost of care)**
- **Score based on group's standardized performance (e.g., how far from national mean).**
- **Identifies statistically significant outliers and assigns them to their respective cost and quality tiers**

	Low cost	Average cost	High cost
High quality	**+2.0x***	**+1.0x***	**+0.0%**
Average quality	**+1.0x***	**+0.0%**	**-0.5%**
Low quality	**+0.0%**	**-0.5%**	**-1.0%**

* Eligible for an additional +1.0x if :

- Reporting quality measures via the web based interface or registries

AND

- Average beneficiary risk score in the top 25% of all beneficiary risk scores

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Are you Paying Attention? (CME Question 1)

When will the value modifier start affecting payments to practices with fewer than 10 eligible professionals?

A. 2015
B. 2016
C. 2017
D. Hasn't been decided yet

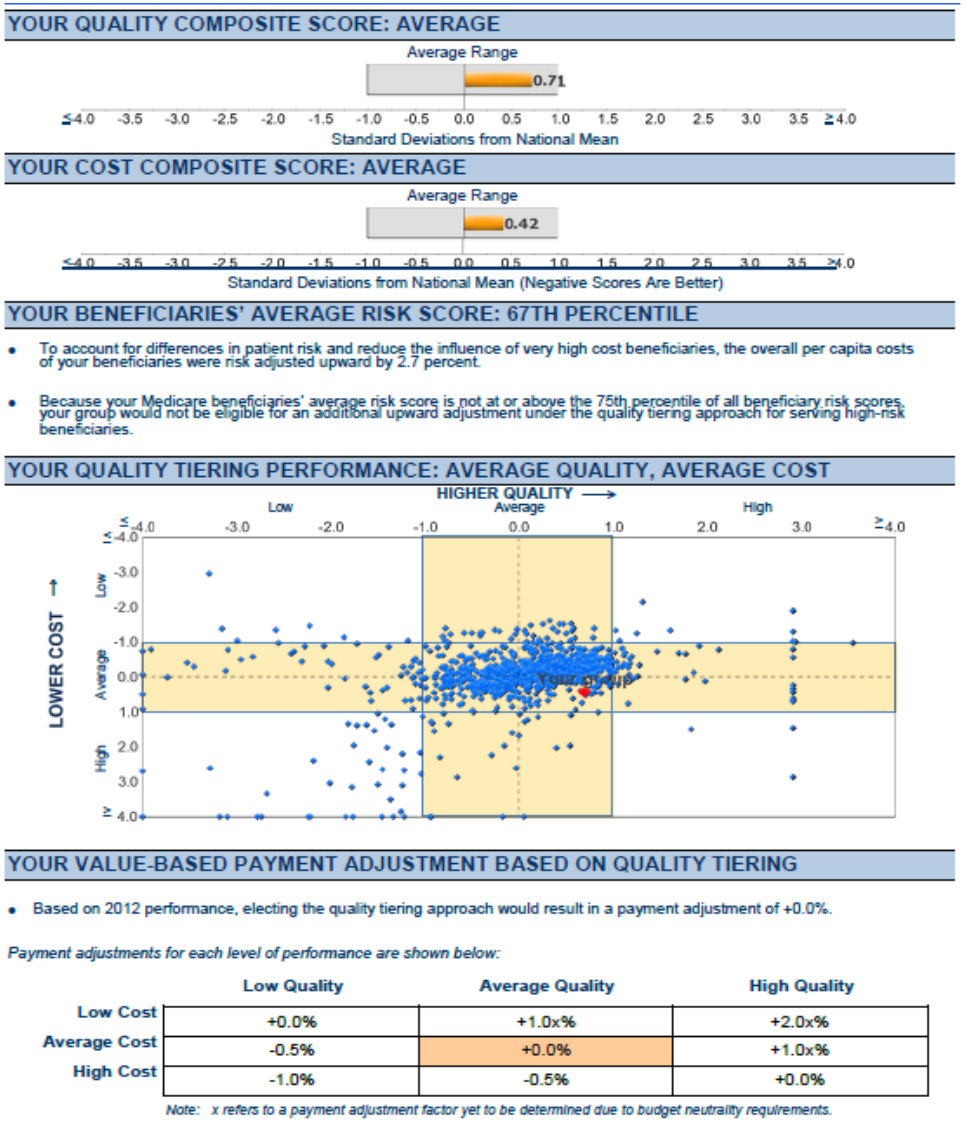
Physician Feedback Reports

- **Late Summer 2014: QRURs for Groups and Solo Practitioners**

- **Drill down tables include beneficiaries attributed to the group, resource use, specific chronic diseases**
  - **All hospitalizations for attributed beneficiaries**
  - **Individual EP PQRS reporting (December 2014)**

What Information Is Included on the Performance Highlights Page?

1. **Your Quality Composite Score**
2. **Your Cost Composite Score**
3. **Your Beneficiaries' Average Risk Score**
4. **Your Quality Tiering Performance Graph**
5. **Your Payment Adjustment Based on Quality Tiering**



YOUR QUALITY COMPOSITE SCORE: AVERAGE

Average Range

0.71

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean

YOUR COST COMPOSITE SCORE: AVERAGE

Average Range

0.42

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Negative Scores Are Better)

YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST

HIGHER QUALITY →

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

LOWER COST ↑

Low ≤-4.0 -3.0 -2.0

Average -1.0 0.0 1.0

High 2.0 3.0 ≥4.0

Your group

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

(payment adjustments in example based on 2015 VM implementation)

Are you Still Paying Attention? (CME Question 2)

The value modifier includes measures of which two dimensions:

A. Volume of services
B. Quality of services
C. Costs of services
D. Medical necessity of services

EHR Incentive Programs

Meaningful Use:
Changes from Stage 1 to Stage 2

Stage 1

Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives

Eligible Hospitals & CAHs

14 core objectives

5 of 10 menu objectives

19 total objectives

Stage 2

Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

Eligible Hospitals & CAHs

16 core objectives

3 of 6 menu objectives

19 total objectives

Payment Adjustments for Providers Eligible for Both EHR Programs

If you are eligible to participate in both Medicare and Medicaid EHR Incentive Programs:

- **You MUST demonstrate meaningful use according to established timelines to avoid payment adjustments**
- **You may demonstrate meaningful use under either Medicare or Medicaid.**

Note: Congress mandated that an EP must be a meaningful user in order to avoid the payment adjustment; therefore receiving a Medicaid EHR incentive payment for adopting, implementing, or upgrading your certified EHR Technology would not exempt you from the payment adjustments.

EP EHR Payment Adjustments

% Adjustment shown below assumes less than 75% of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% Adjustment shown below assumes more than 75% of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

Fraud, Waste, and Abuse

Definitions

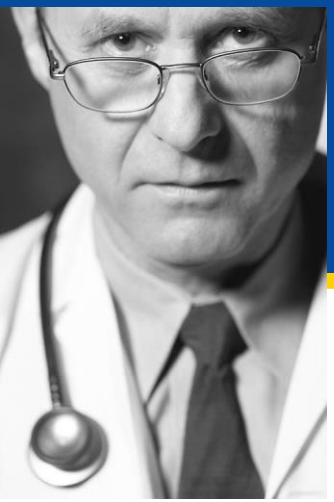
Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts

Waste includes incurring unnecessary costs as a result of deficient management, practices, or controls

Abuse includes excessively or improperly using government resources

Fraud and Abuse Laws

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Statute
- Exclusion Statute
- Civil Monetary Penalties Law



Physician Fraud

Vast majority are honest.

Examples of bad behavior:

- **Receive/solicit/pay kickbacks**
- **Sign orders for unnecessary lab & diagnostic tests**
- **Order DME for beneficiaries who are not their patients**

Medical Identity Theft

- **Definition: misuse of another individual's personal information to obtain or bill for medical goods or services**
- **Creates patient safety risks, professional liability risks, and financial burdens**
  - **Erroneous entries in beneficiaries' medical histories or even wrong medical treatment**
  - **"Framing" a physician for fraud or abuse**
  - **Financial losses for the Medicare Trust Funds and taxpayers.**

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Stay Alert!

Are you Still Awake? (CME Question 3)

Providing a false diagnosis or other information for the sole purpose of helping a patient is not fraud or abuse.

A. True
B. False

Delivery system and payment transformation

Current State –

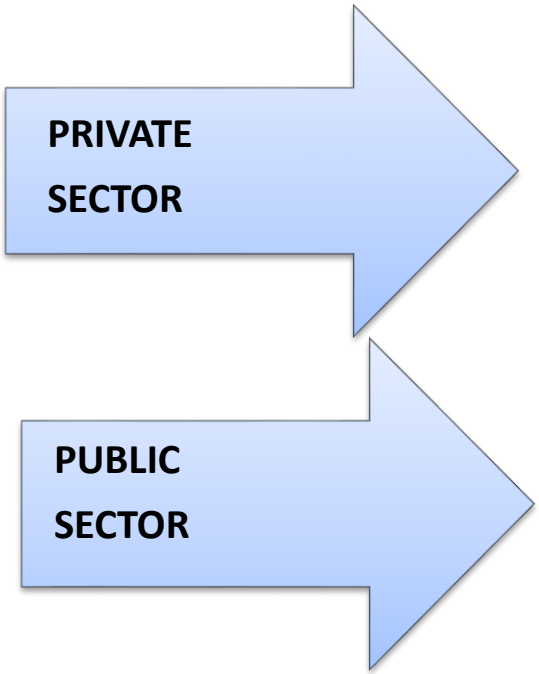
Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems



Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems (and many more)

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt.
- Data Transparency

Moving Forward

- **Continue improving quality and patient safety**
- **Transition to a sustainable patient centered healthcare system**
- **New alternative payment models:**
  - **ACOs, Bundled Payments for Care Improvement, State Innovation Models, etc.**
- **We must make this journey together**

Thank You!

Questions? Comments?

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Web Resources

CMS eHealth Webpage

http://www.cms.gov/ehealth/

- **PQRS Website**
  - **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/**
- **eRx Incentive Program Website**
  - **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/**
- **Medicare and Medicaid EHR Incentive Programs**
  - **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/**
- **Value Based Modifier (VBM)**
  - **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**
- **Frequently Asked Questions (FAQs)**
  - **https://questions.cms.gov/**

Where to Call for Assistance

- **QualityNet Help Desk:** 866-288-8912 (TTY 877-715-6222) , 7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@sdps.org**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - Program and measure-specific questions

(You will be asked to provide basic information such as name, practice, address, phone, and e-mail)

- **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See *Contact Center Directory at:*

    http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

- **EHR Incentive Program Information Center:** 888-734-6433 (TTY 888-734-6563)

Fraud and Abuse Resources

www.cms.hhs.gov/medlearn

Notices, alerts, bulletins, on-line education

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians

www.stopmedicarefraud.gov

Strike Force, prosecution info, press releases, indictments by state, and much more

1-800-HHS-TIPS (800-447-8477)

Report suspected Medicare fraud

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Open Payment Resource

CMS Program Website: Fact Sheets, Frequently Asked Questions, Links

http://go.cms.gov/openpayments

CMS Disclaimer: This information is a summary of the final rule implementing the National Physicians Payment Transparency Program (Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests [CMS-5060-F], codified at 42 CFR Parts 402 and 403) This summary is not intended to override or take the place of the final rule which is the official source for requirements and information on the program.

ICD-10 Implementation

Resources

CMS website:

www.cms.gov/icd10

- **Fact sheets**
- **FAQs**
- **Implementation guides**
- **Timelines**
- **Checklists**

Does CMS Have Your Current Information?

- **Information for the VM and Physician Feedback reports comes from the Provider Enrollment, Chain and Ownership System (PECOS)**
  - **Your medical specialty**
  - **The state in which you practice**
  - **The location of your practice**
  - **Group practice affiliations**
  - **How to contact you**

- **Please update your information at: https://pecos.cms.hhs.gov**

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