

# 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



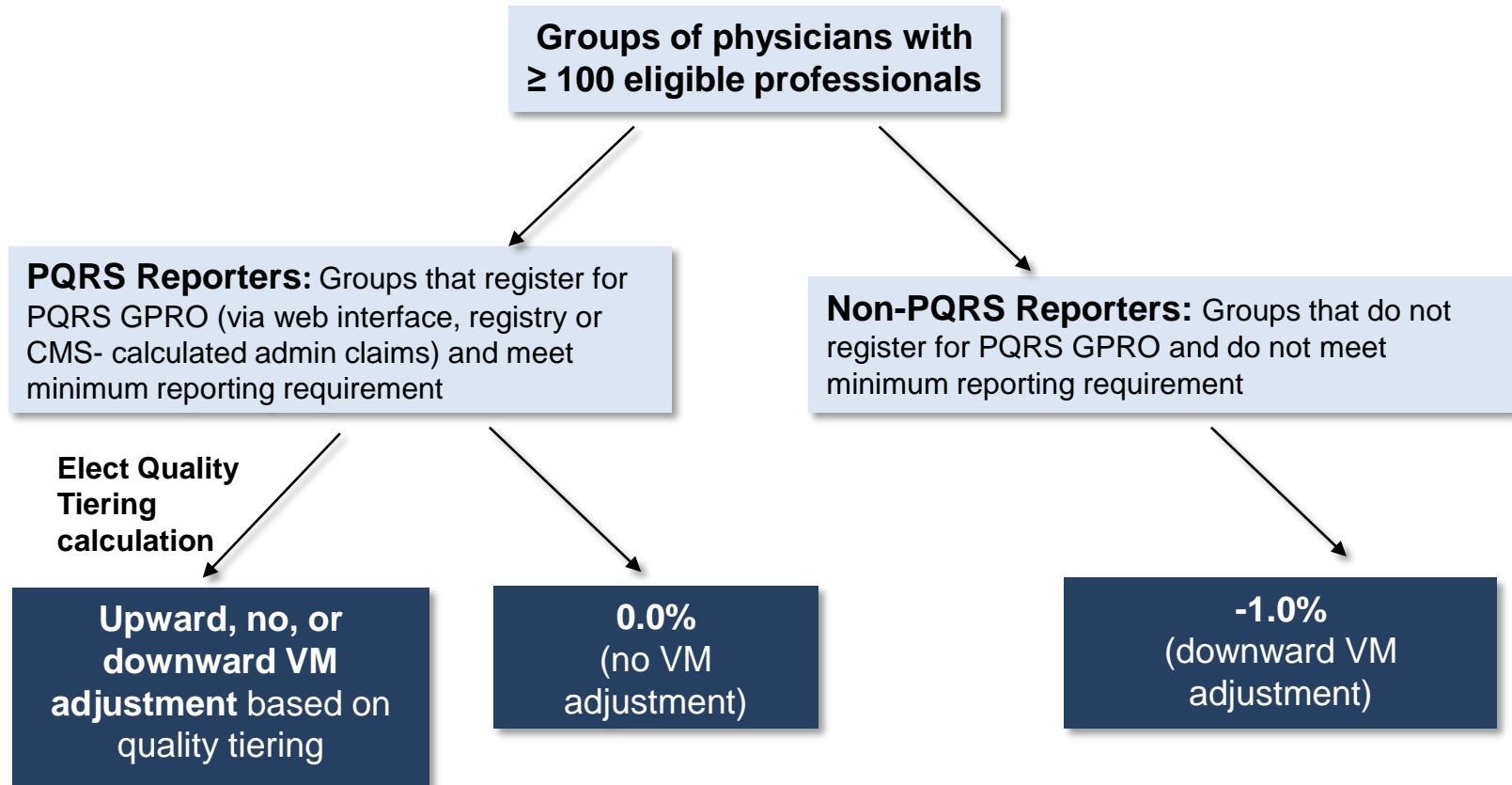
# Value-Based Payment Modifier (VM) Overview

- **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  $\geq 100$  EPs**
  - **2016 - VM applies to physician payment for groups with  $\geq 10$  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

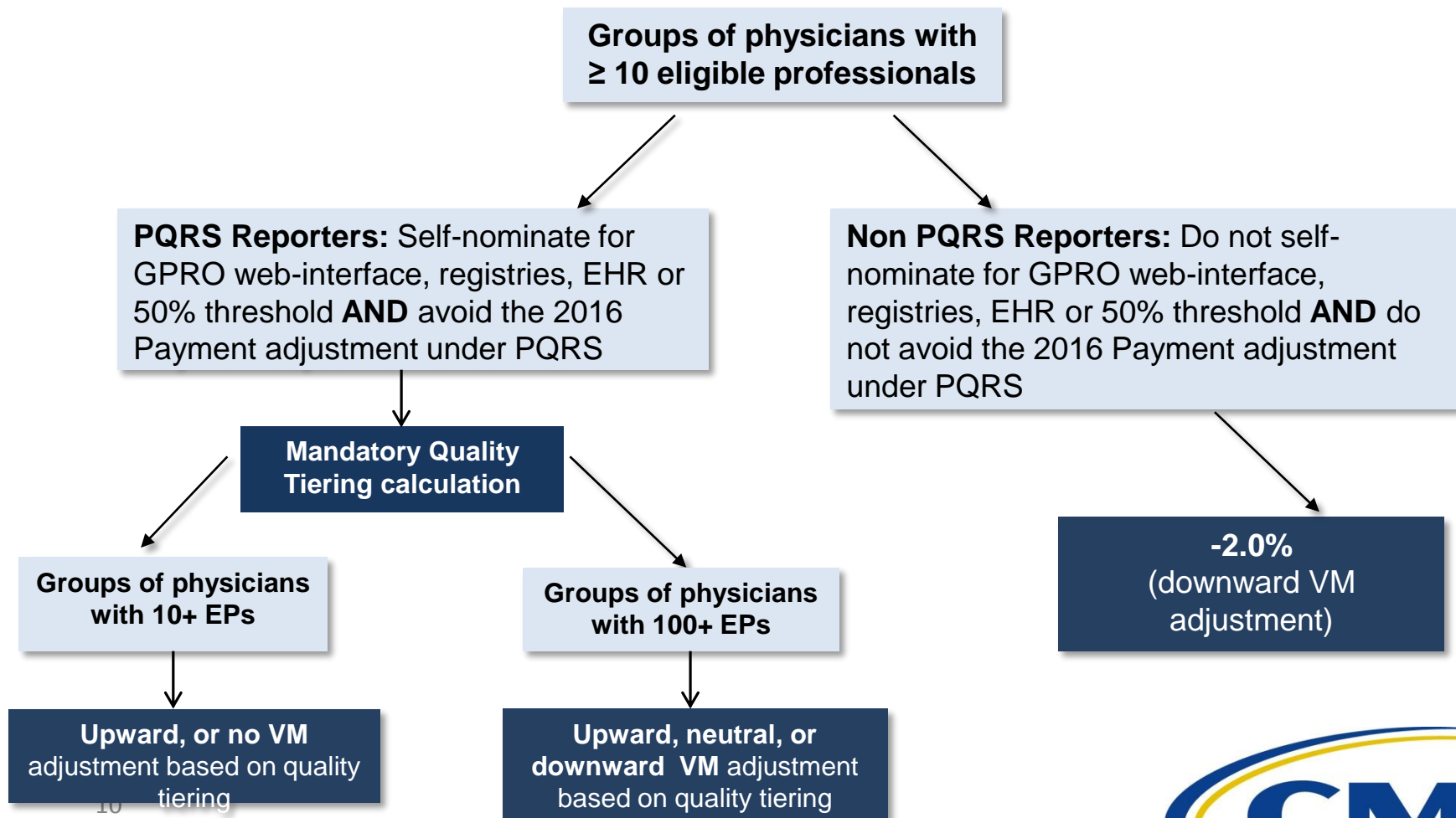
*VM implementation in 2015 is based on PQRS participation in 2013*



**Reporting is a necessary first step towards improving quality.**

# Value Modifier and Physician Quality Reporting System Are Linked, 2016

*VM implementation in 2016 is based on PQRS participation in 2014*



# What Quality Measures will be Used for Quality Tiering?

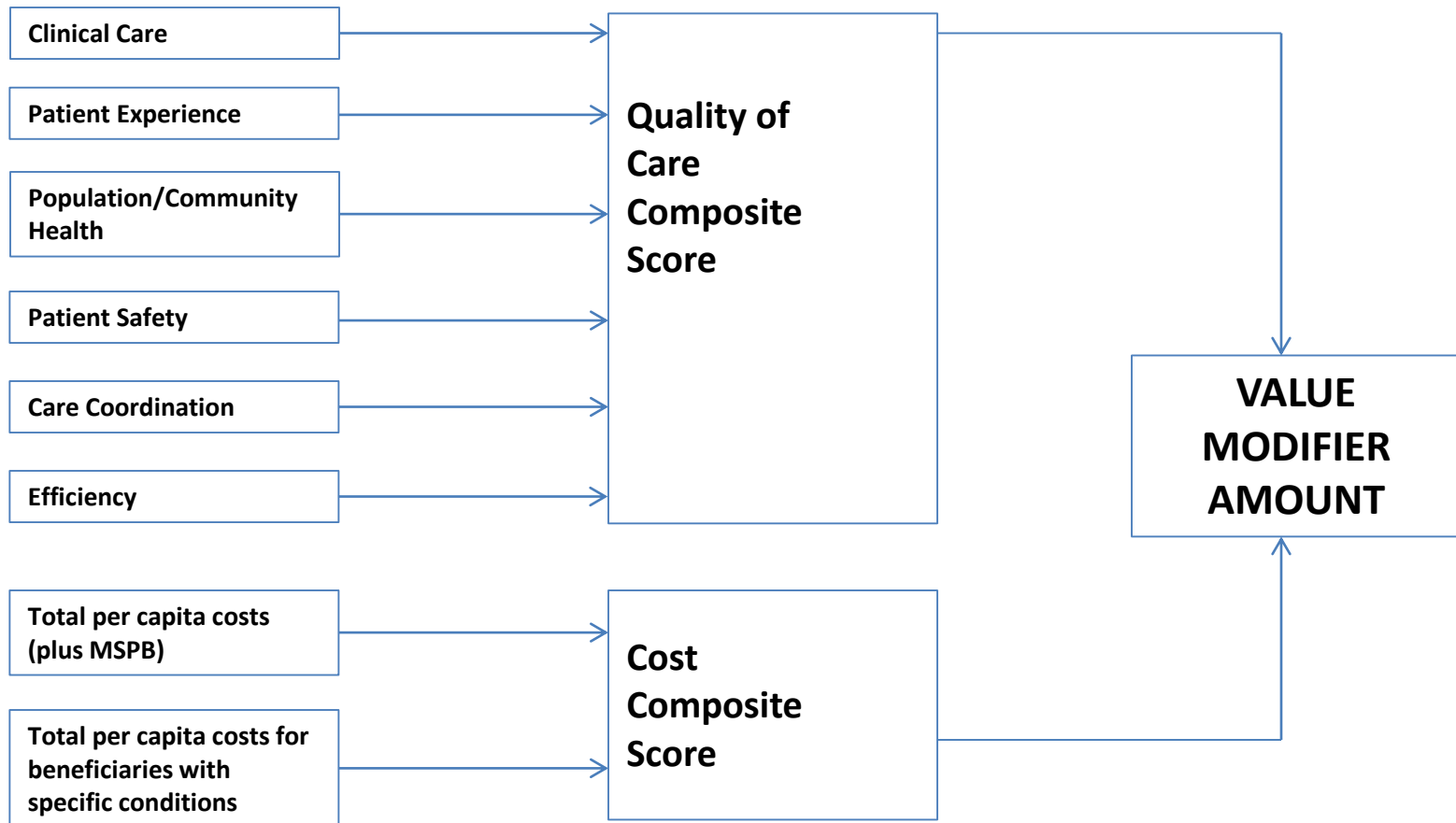
- Measures reported through GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 50% of the eligible professionals within the group
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, 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 professionals

# 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

# Quality-Tiering Methodology

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



# 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

# **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

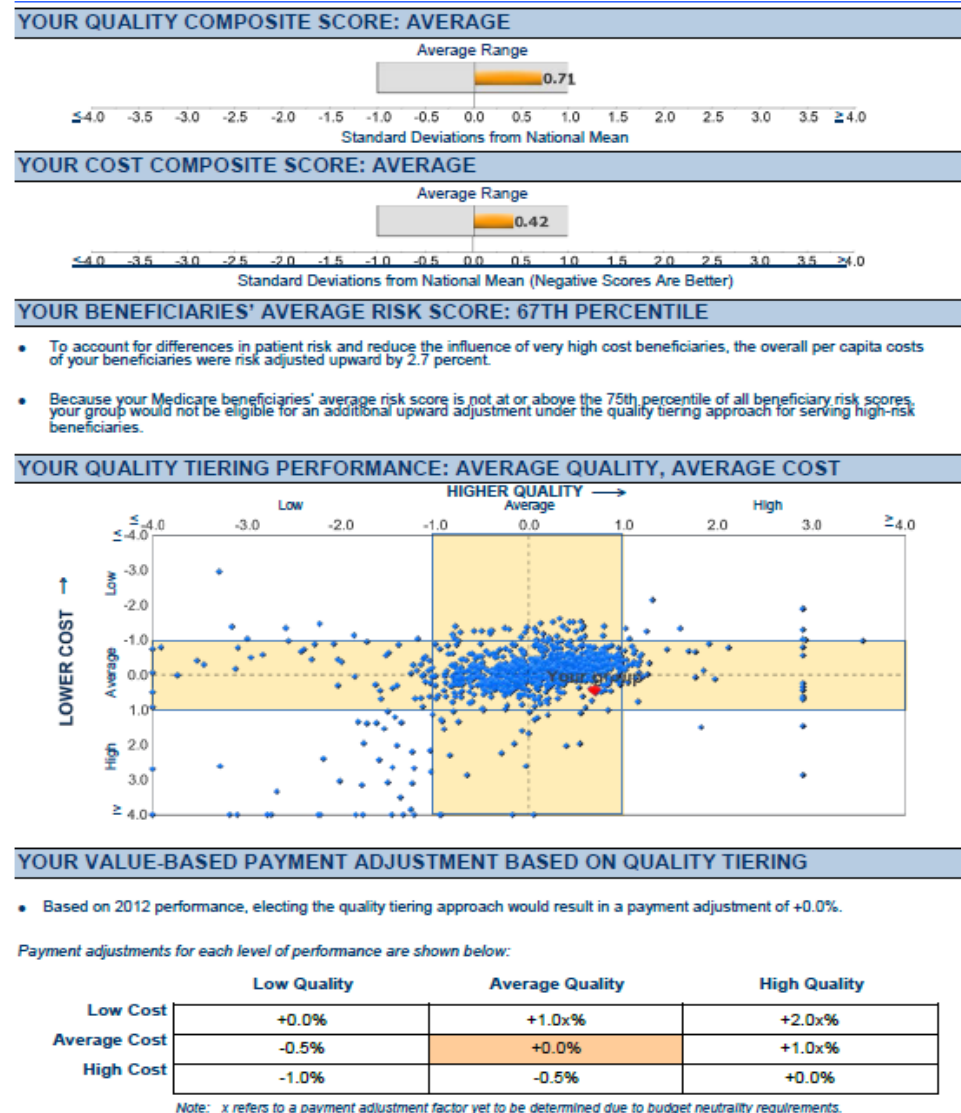
# Physician Feedback Reports

- **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 Tying Performance Graph
5. Your Payment Adjustment Based on Quality Tying



# 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

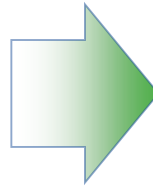
20 total objectives

### **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

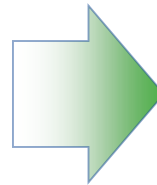
20 total objectives

### **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.**



**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**

The diagram illustrates a transformation from the current state to the future state, categorized by the Private Sector and the Public Sector. Two large blue arrows point from the current state on the left to the future state on the right. The top arrow is labeled 'PRIVATE SECTOR' and the bottom arrow is labeled 'PUBLIC SECTOR'. The current state is characterized by being producer-centered, volume-driven, unsustainable, fragmented, and using fee-for-service (FFS) payment systems. The future state is characterized by being people-centered, outcomes-driven, sustainable, coordinated, and using new payment systems like value-based purchasing, ACOs, shared savings, episode-based payments, medical homes, and data transparency.

**PRIVATE  
SECTOR**

## ***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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415.744.3631



# 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 [gnetsupport@sdps.org](mailto:gnetsupport@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](http://www.cms.hhs.gov/medlearn)

Notices, alerts, bulletins, on-line education

**Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians**

[www.stopmedicarefraud.gov](http://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**

# Open Payment Resource

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

<http://go.cms.gov/openpayments>



The screenshot displays the CMS.gov website. At the top, the CMS.gov logo is visible, along with navigation links: Home, About CMS, Newsroom Center, FAQs, Archive, Share, Help, Email, and Print. Below the logo, a search bar is present with the text "Learn about your healthcare options" and a "Search" button. A horizontal menu bar contains several categories: Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Insurance Oversight, Innovation Center, Regulations and Guidance, Research, Statistics, Data and Systems, and Outreach and Education. The main content area is titled "National Physician Payment Transparency Program: OPEN PAYMENTS". It includes a sub-header "Creating Public Transparency of Industry-Physician Financial Relationships" and a paragraph stating "The Official Website for National Physician Payment Transparency Program: OPEN PAYMENTS (Section 6002 of the Affordable Care Act)". Below this, there is a section for "Check back often for updated tools and resources, plus announcements of future webinars, calls, and meetings." followed by an "Overview" section. The overview explains that the program creates greater transparency around the financial relationships of manufacturers, physicians, and teaching hospitals. It then lists the information required to be reported annually to CMS: applicable manufacturers of covered drugs, devices, biologicals, and medical supplies; applicable manufacturers and applicable group purchasing organizations (GPOs) to report to CMS certain ownership or investment interests held by physicians or their immediate family members; and applicable GPOs to report to CMS payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year. The page concludes with a statement that CMS will collect this data, aggregate it, and publish it on a public website, followed by a section titled "Why OPEN PAYMENTS is Important" which discusses the benefits of collaboration among physicians, teaching hospitals, and industry manufacturers.

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



**ICD-10  
COMPLIANCE DATE  
Oct 1, 2014**

# Resources

CMS website:

[www.cms.gov/icd10](http://www.cms.gov/icd10)

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

The screenshot displays the CMS.gov website interface. At the top, the CMS.gov logo is visible, along with a search bar and a link to "Learn about your healthcare options". Below the header, there are several navigation tabs: Medicare, Medicaid/CHIP, Medicare/Medicaid Coordination, Private Insurance, Innovation Center, Regulations and Guidance, Research, Statistics, Data and Systems, and Outreach and Education. The main content area is titled "ICD-10" and features a large banner with the CMS ICD-10 logo and the text "Official CMS Industry Resources for the ICD-10 Transition www.cms.gov/ICD10". To the left of the main content, there is a sidebar with a list of links under the heading "ICD-10", including "Latest News", "CMS ICD-10 Industry Email Updates", "ICD-10 Implementation Timelines", "CMS Implementation Planning", "Provider Resources", "Medicare Fee-for-Service Provider Resources", "Medicaid Resources", "Payer Resources", "Vendor Resources", "Statute and Regulations", "2014 ICD-10-CM and GEMs", "2014 ICD-10 PCS and GEMs", "2013 ICD-10-CM and GEMs", "2013 ICD-10 PCS and GEMs", "ICD-9-CM Coordination and Maintenance Committee Meetings", "ICD-10 MS-DRG Conversion Project", "CMS Sponsored ICD-10 Teleconferences", and "CMS ICD-10 Industry Email Updates". The main content area also includes sections for "About ICD-10", "Stay up to date on ICD-10!", "CMS Resources", and "Logos".

**ICD-10**

Official CMS Industry Resources for the ICD-10 Transition  
[www.cms.gov/ICD10](http://www.cms.gov/ICD10)

**About ICD-10**

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

The transition to ICD-10 is required for everyone covered by the [Health Insurance Portability Accountability Act \(HIPAA\)](#). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

**Stay up to date on ICD-10!**

Sign up for [CMS ICD-10 Industry Email Updates](#) and follow us on [Twitter](#).

**CMS Resources**

- View the [ICD-10 Introduction](#) fact sheet and [FAQs](#) to get a general overview on ICD-10.
- See official resources designed to help [providers](#), [payers](#), [vendors](#), and [non-covered entities](#) with the transition to ICD-10 on October 1, 2014.
- Access two free Medscape Education modules that provide guidance to small practices making the transition to ICD-10: [ICD-10: A Roadmap for Small Clinical Practices](#) and [ICD-10: Small Practice Guide to a Smooth Transition](#). Continuing medical education (CME) and continuing education (CE) credits are available to physicians and nurses who complete the learning modules.

**Logos**

This official CMS ICD-10 logo (displayed on the top of this page) signifies that these materials were developed by CMS, and are intended for general industry use.

CMS materials intended solely for providers in the Medicare Fee-for-Service program feature the Medicare Learning Network logo.

# 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>