Regulations Driving the New Quality Paradigm

Koryn Rubin

AANS/CNS Senior Manager of Quality Improvement

Patient Protection & Affordable Care Act of 2010 (ACA, P.L. 111-148)

- Expands Coverage to 32 million Individuals
- Investments in Primary/Preventive Care
- Workforce Improvements
- Transparency and Integrity
- **Delivery Reforms Aimed at Enhancing the Value of Health Care**

“Value”

Offering consumers the highest quality product or service at the lowest cost

American Taxpayer Relief Act of 2012 (Pub.L. 112–240)

- **Prevents the 26.5 percent Medicare physician pay cut, extending current Medicare payment through Dec. 32, 2013.**
- **Allows physicians to participate in a clinical data registry to meet Medicare's quality reporting requirements. Takes effect in 2014.**

American Taxpayer Relief Act of 2012 (Pub.L. 112–240) AKA Fiscal Cliff Legislation

- Statutorily, the Secretary must consider the following:

  - The registry has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

  -Require the submission of data from participants with respect to multiple payers;

  -Provides timely performance reports to participants at the individual participant level and;

  -Supports quality improvement initiatives for participants.

- Measures: Do not need to be NQF approved

CMS RFI On Quality Measures in PQRS, EHR Incentive Program and Other Medicare Quality Programs

- CMS issues RFI in response to “Fiscal Cliff” legislation.
- Key Theme: **Alignment!!**

  - Entities already collecting clinical data, such as registries would submit this data on behalf of physicians to satisfy reporting under PQRS and EHR Incentive Program.

  - Physicians reporting quality measures to other programs would satisfy PQRS or EHR Incentive Program.

- Proposed Rule on “aligned” requirements expected Summer 2013

CMS Vision for Quality Measurement

- Align measures with the National Quality Strategy and Six Measure domains
- Implement measures that fill critical gaps within the six domains
- Align measures across CMS programs whenever possible
- Parsimonious sets of measures; core sets of measures
- Removal of measures that are no longer appropriate (e.g. topped out)
- Align measures across measurement enterprise, including public and private sector
- Major aim of measurement is improvement over time

CMS Framework For Measurement Maps To The Six National Quality Strategy Priorities

Clinical quality of care

- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific

Care coordination

- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

Population/ community health

- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

Person- and Caregiver-centered experience and outcomes

- CAHPS or equivalent measures for each settings
- Communication/shared decision-making

Safety

- HAIs
- HACs
- Medication errors

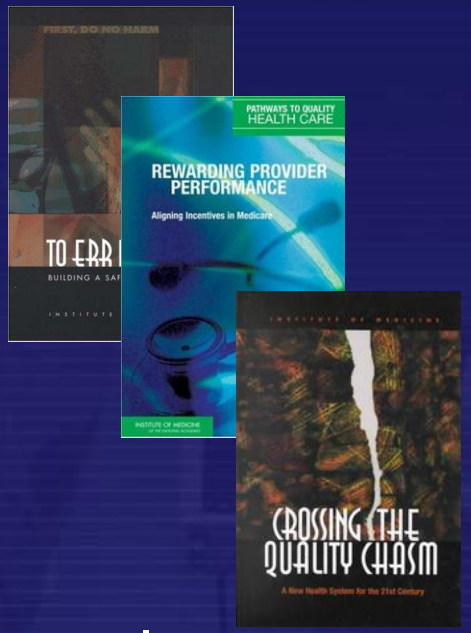
Efficiency and cost reduction

- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

Greatest commonality of measure concepts across domains

Gaps in Quality

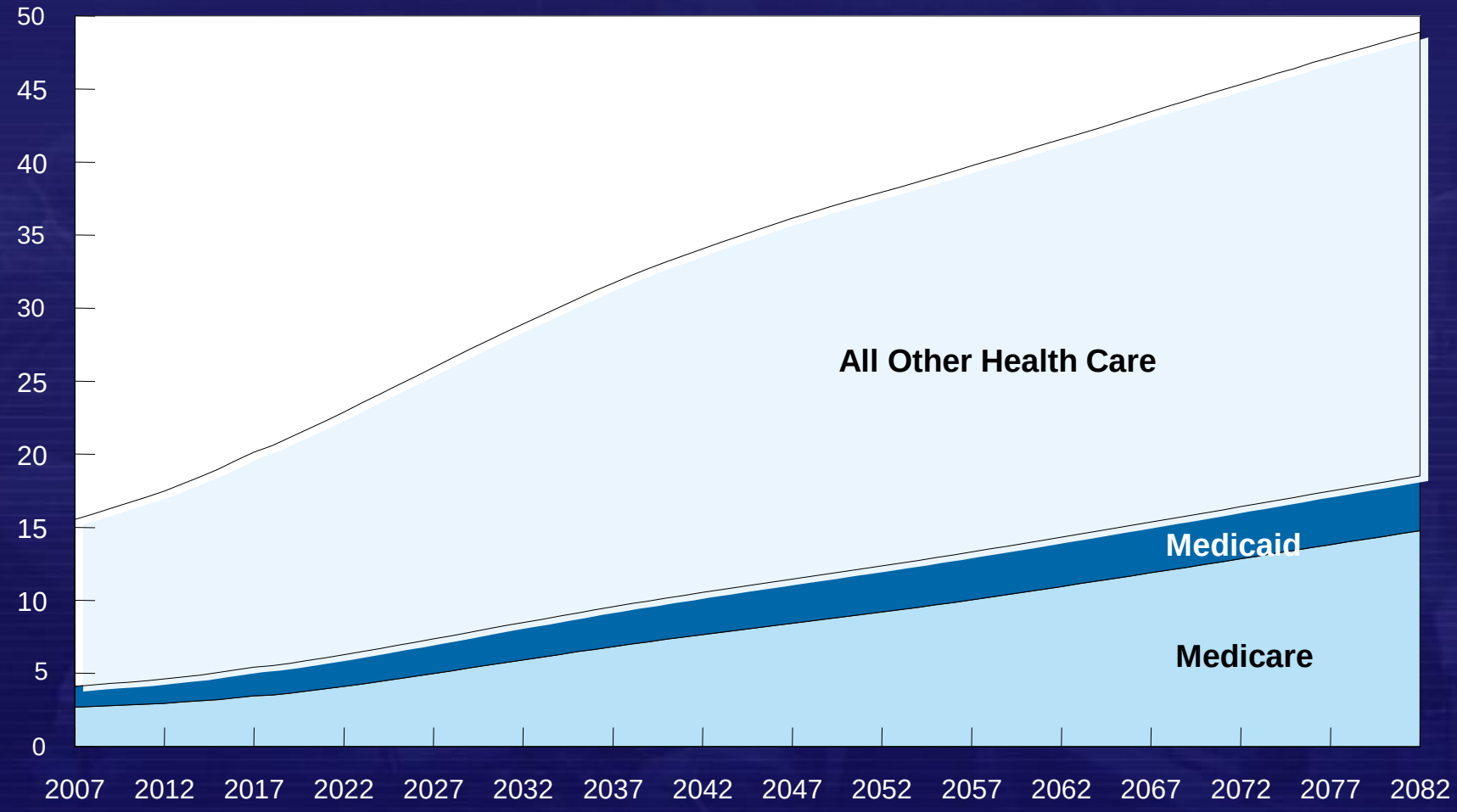


Institute of Medicine (IOM) reports

- To Err is Human (1999)
- Crossing the Quality Chasm (2001)
- Rewarding Provider Performance:
  Aligning Incentives in Medicare (2006)
- Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (2012)

* 44,000 - 98,000 deaths/year due to medical errors
* US medical practice adheres to best evidence only about ½ the time

Projected Spending on Health Care, Percentage of GDP



ACA Reforms: Major Themes

- **Fragmentation → Care Coordination**
  - Silo structure of Medicare: hospitals paid for bundles of services using DRGs (pro-efficiency); physicians paid per service (pro-volume)
  - Misalignment of incentives, poor communication and lack of information flow, unnecessary services
- **FFS Payments → Value-Based Purchasing**
  - Pay currently based on volume not quality or cost
- **Cost Control**: Independent Payment Advisory Board (IPAB) to recommend reductions in Medicare spending

Innovative Payment Models

Center for Medicare & Medicaid Innovation (CMS)

- Established Jan. 1, 2011
- Goal: To test alternative payment and delivery models that improve quality and slow growth in Medicare/Medicaid spending
- To give priority to 20 models specified under law aimed at increasing coordination; reducing unnecessary services; and reducing complications, errors, and hospital readmissions

Innovative Payment Models

Gainsharing Demonstration Project

- Goal: Encourage physician-hospital collaboration by permitting hospitals to share internal savings gained from efforts to improve quality/reduce cost
  - Extends current Medicare gainsharing demos for 2 years
  - Projects must be budget neutral to Medicare

Innovative Payment Models

National Pilot Program on Payment Bundling

- Goal: discourage overuse/fragmented care by bundling payment for multiple provider services
- Begins July 2013; national expansion by 2016 if savings.
- Episode may include: inpatient, outpatient, physician, ER, post-acute services (3 days pre-admission → 30 days post-discharge)
- Different payment approaches: retrospective vs prospective; defined episodes vs all services during inpatient stay

Innovative Payment Models

Medicare Shared Savings Program/

Accountable Care Organizations (ACOs)

- Goal: better coordination of *all services* across *all settings*
- Network of physicians, hospitals, etc. share responsibility for providing care to at least 5,000 Medicare beneficiaries for at least 3 years
- ACOs that meet quality and spending targets rewarded with share of savings achieved for Medicare
- Started in 2012; Pioneer ACOs will be paid on 2013 performance.

Innovative Payment Models

ACOs, cont'd

Numerous concessions/carrots to woo providers:

- Reduced # of quality performance standards
- Phased in approach to tying payment to quality and HIT use
- Prospective assignment of beneficiaries
- Upfront financial support for physician-owned ACOs
- Greater flexibility in governance and legal structure
- Two-track risk model (more risk, more shared savings)
  1) no penalty for increased costs, up to 50% of savings;
  2) pay CMS up to 60% of unexpected cost growth, but share in up to 60% of savings

Linking Hospital Payments to Quality

Hospital Value-Based Purchasing Program

- 2011: 2% cut for failure to *report on* 55 measures
- 2012: pay-for-*performance*
  - Sliding scale payment (highest scoring hospitals receive most)
  - Funded thru reductions in base operating DRGs for all hospital discharges (1.0% in 2013 to 2.0% in 2017)
  - Efficiency measure: Medicare Spending Per Beneficiary

Linking Hospital Payments to Quality

Reduced Payments for Hospital Readmissions

- 1 in 5 readmissions = 20% Medicare budget
- 2012: 1% penalty for preventable 30-day readmissions for 3 high volume/cost conditions (AMI, heart failure, pneumonia)
- 2015: 4 more conditions, 3% penalty, public reporting

Hospital-Acquired Condition Penalty

- More conditions/settings, public reporting, pay based on performance thresholds

Linking Physician Payments to Quality

Medicare Physician Quality Reporting System (PQRS)

- Gradually declining bonus (1% in 2011, 0.5% in 2012-14)
- Additional 0.5% bonus for enhanced MOC participation
- ***PENALTIES*** 1.5% cut in 2015; 2% cut thereafter
- Over 130 measures; ~30 applicable to neurosurgery
- Reporting through registries and EHRs, but still heavy reliance on claims data

Linking Physician Payments to Quality

Medicare Physician Quality Reporting System (PQRS)

- Individuals: Qualify for PQRS bonus or report one measures or measure group (via claims, EHR or registry) or participate in administrative claims reporting

- Groups > 25: Qualify for PQRS bonus or report one measure (via web interface or registry) or participate in administrative claims reporting program.

2013 PQRS Measures Applicable to Neurosurgery

Perioperative Care	Stroke	Low Back Pain
▪Timing of Antibiotic Prophylaxis: Ordering Physician ▪Timing of Prophylactic Abx: Administering MD ▪Discontinuation of Prophylactic Abx ▪VTE Prophylaxis ▪Selection of Prophylactic Abx: 1st/2nd Generation Cephalosporin	▪DVT Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage ▪Discharged on Antiplatelet Tx ▪Rehabilitation Services Ordered ▪Screening for Dysphagia	▪Actions Taken at Initial Visit (pain and functional assmnt, patient history, etc) ▪Physical Exam at Initial Visit ▪Advice for Normal Activities ▪Advice Against Bed Rest

Linking Physician Payments to Quality

Physician Resource Use Feedback Program

- Confidential feedback reports to physicians comparing relative spending for select episodes
- Commercial episode grouper software posed challenges
- 2011: per capita spending on patients with 5 chronic conditions (diabetes, CHF, CAD, COPD, prostate cancer)
- Pilot reports released to groups 25 or more in CA, IO, KS, MO, NE*

* Access report at: www.qrurinfo.com

Linking Physician Payment to Quality

Value-Based Payment Modifier

- Differential Medicare payments based on relative quality and costs; 2015-2017 phase-in

- Budget neutral

-Groups > 100: Participate in PQRS or apply to participate and hope to qualify for bonus

-0.0% bonus or penalty if participating in PQRS

-Not required for MDs in groups under 100 until 2017, when VBM applies to all MDs

Linking Physician Payment to Quality

Value-Based Payment Modifier

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

Health Information Technology

Medicare E-Prescribing Incentive Program

- To avoid the 2013 penalty, MDs needed to qualify in 2011; to avoid the 2014 penalty, MDs needed to qualify in 2012
- Program merges with EHR program in 2015

Health Information Technology

Medicare EHR Incentive Program

- Adopt a federally certified EHR and demonstrate "meaningful use" of the system
- Phased-in demonstration of MU: attest to using system to collect process of care data → use collected data to make point-of-care decisions
- Start dates: 2011-2015
- Earlier you start, more you can earn (up to $40,000 over 5 years for physicians)
- ***PENALTIES*** 1.0% in 2015, 3.0% in 2017, 5.0% thereafter

Medicare EHR Incentive Program

Start Date	Medicare Incentive Payment						
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**
2011	$18,000	$12,000	$8,000	$4,000	$2,000	0	**$44,000**
2012		$18,000	$12,000	$8,000	$4,000	$2,000	**$44,000**
2013			$15,000	$12,000	$8,000	$4,000	**$39,000**
2014				$12,000	$8,000	$4,000	**$24,000**
2015					0	0	**0**

Public Reporting of Physician Performance

Physician Compare Website

- Contact info, credentials, Medicare participation
- As of 2011, successful participation in PQRS
- By 2013, report data on practices participating in ACOs and PQRS GPRO
- Next five years, CMS expand to include:
  - Patient outcomes
  - Resource utilization
  - Patient satisfaction

What Do The Programs Mean To Physicians?

Total Cuts (worse case scenario)

	Deficit Reduction Sequester	PQRS	e-Rx	EHR	Value Based Payment Modifier
2013	-2		-1.5		
2014	-2		-2		
2015	-2	-1.5		-1	-1
2016	-2	-2		-2	?
2017	-2	-2		-3	?
2018	-2	-2		-3	?
2019	-2	-2		-4	?
2020	-2	-2		-5	?
2021	-2	-2		-5	?

Various CMS Quality and Performance Programs

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
•Medicare and Medicaid EHR Incentive Program	• Medicare and Medicaid EHR Incentive Program	• Inpatient Rehabilitation Facility	• Medicare Shared Savings Program	•Medicaid Adult Quality Reporting*
•PPS-Exempt Cancer Hospitals	• PQRS	• Nursing Home Compare Measures	• Hospital Value-based Purchasing	• CHIPRA Quality Reporting*
•Inpatient Psychiatric Facilities	• eRx quality reporting	• LTCH Quality Reporting	• Physician Feedback/Value -based Modifier*	• Health Insurance Exchange Quality Reporting*
•Inpatient Quality Reporting		• Hospice Quality Reporting	• ESRD QIP	• Medicare Part C*
•HAC payment reduction program		• Home Health Quality Reporting		• Medicare Part D*
•Readmission reduction program				
•Outpatient Quality Reporting				
•Ambulatory Surgical Centers				

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

Comparative Effectiveness Research

- Research to compare different prevention, diagnosis or treatment options to see which work best in different patient populations
- 2009 Recovery Act: $1.1 billion for CER
- 2010 ACA: new permanent infrastructure
  - Patient-Centered Outcomes Research Institute (PCORI): prioritize, coordinate and develop appropriate methodologies for CER (trust fund: $500 million by 2015)
  - No authority to mandate coverage/reimbursement, but doesn't forbid payers from using CER to inform such decisions

Cost Containment

- **Independent Payment Advisory Board**
  - 15 non-elected government officials appointed by President
  - ***MAIN*** purpose: to recommend cuts in Medicare when spending exceeds a target growth rate
  - Recommendations become law unless Congress passes alternative on fast-track basis (7 months)
  - Expected savings: $16 billion over 10 years
  - Effective 2014; hospitals exempt until 2020

Positioning Neurosurgery in Quality World

- AANS/CNS proposed 2 episodes of care for bundled payments; carotid stenosis and grade 1 single level spondy
- Expand recognition and participation in N2QOD
  - Stakeholder outreach
  - Qualify N2QOD as CMS-approved registry
- Evaluating participating in *Choosing Wisely* Campaign

The Road Ahead

ACA did not repeal Medicare's SGR

- Formula ties spending on physician services to overall economy, not actual practice costs
- Delay in permanently fixing formula: $48 billion in 2005→ $138 billion today
- Continued short-term interventions are unsustainable
- SGR cuts + VBP penalties + IPAB cuts = RECIPE FOR DISASTER

The Road Ahead

Ideas to Replace SGR All In Include Quality Tied to Payment!

- Medicare Physician Payment Innovation Act (H.R. 574):
  - Repeals the SGR and provides five years of stable payments to doctors while new payment models are tested.
  - Physicians then would receive incentives to move toward coordinated care models.
- House Ways and Means Proposal

The Road Ahead

Private insurer programs modeled off of ACA

- Impact of these reforms felt beyond Medicare

The Road Ahead

Critical that medical profession steer the ship

- Collect own data to identify where variability and waste exist and to develop more precise indications to guide practice (National Neurosurgery Quality Outcomes Database)
- Develop more appropriate and meaningful measures of cost and quality based on highest levels of evidence
- Develop more complex risk-adjustment mechanisms to account for individual patient needs

Questions??

- Contact Info: Koryn Rubin, Senior Manager, Quality Improvement

  Email: krubin@neurosurgery.org