CMS Quality Based Payment Reform Initiatives
Health Care Compliance Association
18th Annual Compliance Institute
San Diego, CA
Tuesday April 1, 2014
Peter D. Ricoy
Healthcare Attorney
Schwabe, Williamson & Wyatt, P.C.

Outline
• Background: Cost Drivers of Payment Reforms
• Pay for Performance Concepts
• Specific CMS Initiatives:
  – Hospital Inpatient Reporting Program
  – Hospital Outpatient Reporting Program
  – Hospital Value Based Purchasing
  – Physician Quality Reporting System
  – Ambulatory Surgery Center Quality Reporting
  – Others
• Cases
• Conclusions

Health Expenditures Growing
Source: Centers for Medicare & Medicaid Services, Office of the Actuary; National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census
Medicaid Enrollment, 2002-2011

Projected Medicaid Enrollment

Projected Medicare Enrollment

Source: Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011, CMS.
Medical Errors are Prevalent
• Healthcare errors are believed to harm millions of patients each year and add billions to healthcare costs.
• The CDC estimates 1.7 million healthcare associated infections occur each year, leading to 99,000 deaths
• Adverse Medication Events Cause More than 77,000 injuries and deaths each year
• CBO found that there were over 180,000 severe injuries attributable to medical negligence in 2003.
• OIG found that one in seven Medicare patients are injured during hospital stays and that adverse events during the course of care contribute to the deaths of 180,000 patients every year

Historical Context of Medicare Reimbursement Methods
• Hospital Cost-Based
• Fee for Service
• DRGs & RVUs
• Capitation Models
• Quality and Value Initiatives
• ACOs

National Strategy for Quality Improvement in Health Care
• Section 3011 of PPACA Required the Establishment of a National Strategy to Improve:
  – Delivery of Health Care Services
  – Patient Health Outcomes
  – Population Health
• CMS required to identify national priorities that:
  – Have greatest potential for improving health outcomes, efficiency, and patient-centeredness
  – Identify areas for rapid improvement in quality and efficiency
  – Improve federal payment policy to emphasize quality and efficiency.
  – Enhance use of health care data, and others
National Strategy for Quality Improvement in Health Care

• Develop comprehensive plan to achieve priorities
  – Must address coordination among agencies
  – Establish benchmarks for agencies
  – Develop reporting by agencies of implementation
  – Align public and private payers re quality and patient safety
• Submit plan to Congress and regularly update

National Strategy for Quality Improvement in Health Care

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Hospital Inpatient Reporting Program (IQR)

• Established by sec. 5001(a) of the Deficit Reduction Act of 2005 (P.L. 109-171)
• Participating Hospitals Submit Quality Indicators
• Failure to Submit Results in Reduction of the Annual Payment Update (APU) (Market Basket Increase) by two Percentage Points
Hospital Inpatient Reporting Program (IQR)

- **Sample Clinical Categories of Indicators Collected**
  - Acute Myocardial Infarction (AMI)
  - Heart Failure
  - Stroke
  - Venous Thromboembolism (VTE)
  - Pneumonia (PN)
  - Children’s Asthma Care (CAC)
  - Surgical Care Improvement Project (SCIP)
  - Emergency Department (ED)**

Hospital Inpatient Reporting Program (IQR)

**Sample Measures**

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Submission Required</th>
<th>Defined Definition</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction (AMI)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia (PN)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Asthma Care (CAC)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Care Improvement Project (SCIP)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department (ED)**</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital Inpatient Reporting Program (IQR)

- **Categories of Data Required:**
  - Measures Requiring Abstraction and Submission by the Hospital or its Vendor
    - Example: Median Time from ED Arrival to ED Departure for Admitted ED Patients - Overall Rate
  - Measures Requiring Web-Based Hospital Data Entry
    - Participation in a Systematic Clinical Database Registry for Stroke Care
  - Measure Information Obtained from Claims-Based Data
    - Pneumonia (PN) 30-Day Readmission Rate (7)
Hospital Inpatient Reporting Program (IQR)

- CMS & AHRQ developed the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS);
- Survey asks patients 27 questions about their hospital experience, including:
  - communication with doctors,
  - communication with nurses,
  - responsiveness of hospital staff,
  - cleanliness and quietness of hospital environment,
  - pain management,
  - overall rating of hospital.

Data is Posted Online at Hospital Compare Web Site:
Hospital Inpatient Reporting Program (IQR)

- Accuracy: Hospitals must pass the validation requirement of a minimum of 75% reliability based on chart-audit validation for clinical process measures
- A random sample of 800 hospitals is selected for validation annually
- Hospitals who did not meet the 75% threshold for the previous year are also selected.

Hospital Inpatient Reporting Program (IQR)

Reconsideration / Appeals

- IQR Program reconsideration from CMS must submit their request within 30 days following the date identified on Hospital IQR Program Annual Payment Update (APU) notification letter
- The request must identify the hospital’s specific reason(s) for believing the Hospital IQR Program requirements were met and why the hospital should receive the full Inpatient Prospective Payment Systems (IPPS) APU
- When a hospital is dissatisfied with the result of CMS’s reconsideration, the hospital may file a claim under 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board [PRRB] appeal).

Hospital Inpatient Reporting Program (IQR)

- Authorities & Information
  - Section 1886(b)(3)(B)(viii) of the Social Security Act
  - Code Federal Regulations: 42 CFR 412.140
  - FY 2014 IPPS Final Rule: 78 FR 50775
  - http://www.qualitynet.org/
  - qnetsupport@sdps.org
  - QualityNet Help Desk: 1-866-288-8912
  - Your State’s QIO
Hospital Outpatient Reporting Program (OQR)

- Program established under the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006
- The first reporting period began with April 1, 2008 patient encounter dates
- Voluntary quality measure data reporting program for outpatient hospital services;
- Modeled on the Hospital Inpatient Reporting Program

Hospital Outpatient Quality Reporting (OQR) Program Overview

- Hospitals that Fail to Meet Receive two percent Reduction in OPPS annual payment update
- Reduction only impacts payment year involved
- CMS Prefers to adopt National Quality Forum measures
- CMS focuses on “high impact” reporting measures
- 27 Measures, including:
  - Clinical Performance
  - Imaging Efficiency
  - Web-Based Structural
- Public Reporting of Data

Hospital Outpatient Reporting Program (OQR) Measures

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-1</td>
<td>Median Time to Fibrinolysis</td>
</tr>
<tr>
<td>OP-2</td>
<td>Fibrinolytic Therapy Initiated Within 30 Minutes of ED Arrival</td>
</tr>
<tr>
<td>OP-3</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
</tr>
<tr>
<td>OP-4</td>
<td>Aspirin at Arrival</td>
</tr>
<tr>
<td>OP-5</td>
<td>Median Time to ECG</td>
</tr>
<tr>
<td>OP-6</td>
<td>Timing of Antibiotic Prophylaxis for Surgical Patients</td>
</tr>
<tr>
<td>OP-7</td>
<td>MRI Lumbar Spine for Low Back Pain</td>
</tr>
<tr>
<td>OP-8</td>
<td>Mammography Follow-up Rates</td>
</tr>
<tr>
<td>OP-9</td>
<td>Abdomen CT Use of Contrast Material</td>
</tr>
<tr>
<td>OP-10</td>
<td>Thorax CT Use of Contrast Material</td>
</tr>
<tr>
<td>OP-11</td>
<td>The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data</td>
</tr>
<tr>
<td>OP-12</td>
<td>Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery</td>
</tr>
<tr>
<td>OP-13</td>
<td>Surgical Use of Mammographic Localization in Low and High Risk of Breast Cancer</td>
</tr>
<tr>
<td>OP-14</td>
<td>Use of Brain CT in the Emergency Department (ED) for Acute Respiratory - Reporting Postponed*</td>
</tr>
<tr>
<td>OP-15</td>
<td>Reporting Medical Records between Visits</td>
</tr>
</tbody>
</table>
Hospital Outpatient Reporting Program (OQR)

Measures

**Hospital OQR Quality Measures**

- **OP-18**: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- **OP-19**: Transition Record with Specified Elements Received by Discharged Patients - MEASURE REMOVED
- **OP-20**: Door to Diagnostic Evaluation by a Qualified Medical Professional
- **OP-21**: ED-Median Time to Pain Management for Long Bone Fracture
- **OP-22**: ED-Patient Left Without Being Seen (Numerator/denominator one time per year for designated reference period)
- **OP-23**: ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Reached Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival
- **OP-24**: Safe Surgery Checklist Use
- **OP-25**: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
- **OP-26**: Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures
- **OP-27**: Influenza Vaccination Coverage Among Healthcare Personnel (reported on the National Healthcare Safety Network website)
- **OP-28**: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- **OP-29**: Cataracts – Improvement in Patient’s Visual Function Within 90 Days Following Cataract Surgery
- **OP-30**: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

**Authorities & Information**

- Section 1833(t)(17)(A) of Social Security Act
- Code Federal Regulations: 42 CFR 419.46
- FY 2014 IPPS Final Rule: 78 FR 75090
- http://www.qualitynet.org/
- qnetsupport@sdps.org
- QualityNet Help Desk: 1-866-288-8912
- Your State’s QIO

**Hospital Value Based Purchasing**

- Established by Section 3001(a) of Affordable Care Act
- Information posted on hospital compare web site
- CMS will select measures as subset of Hospital Inpatient Quality Reporting Program
- If a hospital meets or exceeds the performance standards, CMS will make value-based incentive payments to the hospital
Hospital Value Based Purchasing

- Funded by a 1% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2013, increasing to 2% by FY 2017
- Value Based Incentive Payment Percentage by Program Fiscal Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1.0</td>
</tr>
<tr>
<td>2014</td>
<td>1.25</td>
</tr>
<tr>
<td>2015</td>
<td>1.5</td>
</tr>
<tr>
<td>2016</td>
<td>1.75</td>
</tr>
<tr>
<td>2017</td>
<td>2.0</td>
</tr>
</tbody>
</table>

- Funded by a 1% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2013, increasing to 2% by FY 2017
- Value Based Incentive Payment Percentage by Program Fiscal Year

- For each hospital, a “Total Performance Score” is calculated ranging from 0 to 100 based on its performance under the measures;

- Authorities & Information
  - Section 1886(o) of Social Security Act
  - FY 2014 IPPS Final Rule: 78 FR 75120
  - http://www.qualitynet.org/
Physician Quality Reporting System

- Tax Relief and Health Care Act of 2006 (TRHCA) initially authorized the Physician Quality Reporting System.
- PQRS uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).
- Individual EPs who meet satisfactory submission of PQRS quality measures data for services furnished during a 2014 will qualify to earn a PQRS incentive payment equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period.

Physician Quality Reporting System

- Medicare physicians
  - Doctor of Medicine
  - Doctor of Osteopathy
  - Doctor of Podiatric Medicine
  - Doctor of Optometry
  - Doctor of Dental Medicine
  - Doctor of Chiropractic
- Practitioners
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
- Therapists
  - Physical Therapist
  - Registered Dietician
  - Nutrition Professional
  - Audiologists

Physician Quality Reporting System

- Group practices can register to participate in PQRS through the group practice reporting option (GPRO) to be analyzed at the group level.
- A “group practice” under 2014 PQRS consists of a physician group practice, as defined by a single Tax Identification Number (TIN), with 2 or more individual EPs.
- An individual EP who is a member of a group practice participating in PQRS GPRO is not eligible to separately earn a PQRS incentive payment as an individual EP.
Physician Quality Reporting System

- Reporting options generally require an EP or group practice to report 9 or more measures covering at least 3 National Quality Strategy (NQS) domains:
  - Patient Safety
  - Person and Caregiver-Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction

Individual EPs may choose to report quality data via:

1. EHR Direct Product that is Certified Electronic Health Record Technology (CEHRT)
2. EHR data submission vendor that is CEHRT
3. A qualified PQRS registry
4. Participation through a Qualified Clinical Data Registry (QCDR)
5. Medicare Part B claims submitted to CMS

Authorities & Information

- Section 1848(a), 1848(k), & 1848(m) of the Social Security Act
- Code Federal Regulations: 42 CFR 414.90
- 77 FR 44805
Ambulatory Surgery Center Quality Reporting

- Tax Relief and Health Care Act of 2006 (TRHCA) initially authorized the ASCQR Program
- Section 1833(i)(2)(D)(iv) of the Act authorizes CMS to implement payment system “in a manner so as to provide for a reduction in any annual update for failure to report on quality measures
- Intended to mirror the hospital outpatient quality program

Ambulatory Surgery Center Quality Reporting

- An ASC that Fails to Meet Reporting Requirements has a 2% Reduction to any Annual Increase Provided Under the Revised ASC Payment System
- APU Rates are Effected Starting in CY 2014
- Reductions for One Year Are Not Taken into Account in Computing Annual Increase for Subsequent Year

Ambulatory Surgery Center Quality Reporting

ASC Quality Measures

ASC-1: Patient Burn
ASC-2: Patient Fall
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
ASC-4: Hospital Transfer/Admission
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing
ASC-6: Safe Surgery Checklist Use
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures
ASC-8: Influenza Vaccination Coverage among Healthcare Personnel
ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps: Avoidance of Inappropriate Use
ASC-11: Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery
Ambulatory Surgery Center Quality Reporting

- Authorities & Information
  - Section 1833(i)(2)(D)(iv) of the Social Security Act
  - 78 FR 75130

Other CMS Programs

- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-term Care Hospitals Quality Reporting Program (LTCHQRP)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Other CMS Programs

- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program
- End-Stage Renal Disease (ESRD) Quality Initiative
- Hospital Readmissions Reduction Program
- Hospital Acquired Conditions Reduction Program
Cases

- Valley Presbyterian Hospital (Van Nuys, CA) v. BlueCross BlueShield Association/First Coast Service Options, PRRB Hearing Dec. No. 2011-D28, Case No. 08-2579, May 13, 2011.
- CMS Reduced Market Basket Increase by 2.0 for FY 2008 due to failure to Conduct a Dry Run Submittal.
- Hospital Submitted Majority of Quality Data on Time, But Did Not Meet All Statutory Requirements
- Hospital: Prolonged Technology Problems Interfered with Ability to Participate and Vendor Failed to Notify Hospital of Dry Run Requirement
- Hospital: Substantial Performance
- Held: Secretary defined precisely what was required, and hospital failed to meet.

Cases (Continued)

- Hospital failed to submit required hospital quality data by deadline.
- Hospital: we acted reasonably, diligently and good faith. The vendor missed the submission deadline due to a technical error, and the error was corrected promptly and the data was submitted 12 hours after the deadline expired.
- Hospital: we “substantially complied” with requirements and CMF suffered no damages as the result of minor breach.
- Intermediary: 4.5 months following last day of discharge to submit quality data to the QIO – plenty of time.
- Held: Hospital failed to comply with requirements, hospital not entitled to full market basket update.

Cases (Continued)

- Hospital argued that CMS did not follow APA requirements by giving proper notice of CMS’ scoring methodology for parent/child questions.
- Intermediary argued that notice was provided though QualityNet.org.
- Held: CMS published policy is inconsistent with CMS practice and clearly did not provide hospitals with notice relative to the scoring methodology for parent/child questions or the penalties that result from answering a parent question incorrectly.
Conclusions

- CMS Programs Likely to Continue & Increase
- President’s FY 2015 Budget Proposal
- Impact on State Initiatives
- Impact on Commercial Payers

Questions?

Contact information:

Peter D. Ricoy
Shareholder Attorney
Schwabe, Williamson, & Wyatt, P.C.
1211 SW 5th Ave., Ste. 1900, Portland, OR 97204

Direct: 503-796-2973
Email: pricoy@schwabe.com