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Practice without boundaries

Understanding Value-Based Care & P4P

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SIMPLIFY *the Everyday*

AMD

HEALTHCARE SOLUTIONS

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Objectives

- Define Value Based Care
- Describe P4P, Physician Quality Reporting
- As industry leaders, identify areas that will advance value based care, develop systems that focus on quality and puts patients at the center of our focus, while maximizing revenues.

Providers who can deliver the clinical and financial innovation strategies in our new post-reform, volume-to-value world, will be the providers in the next century of healthcare.

Healthcare Reform Changes-Affordable Care Act

- Value Based Payment
- Triple Aim
- Quality Reporting Programs
  - Hospital Readmission Reduction Program
  - Hospitals have Medicare Penalties and Value-Based initiatives
  - Transparency
- Accountable Care Organizations
- Value Based Payment
- New Hospital-Acquired Condition Reduction Program

Healthcare reform to save 660 million annually 3.2 billion over 5 years

Healthcare Reform Changes-Affordable Care Act

- Post Acute Care Programs
  - Nursing Home Collaborative (Nursing Home Compare, New Survey Processes)
  - QAPI (Quality Assurance & Performance Improvement)
  - Reducing Readmissions – Penalties Coming Soon
  - New legislation – IMPACT Act

We need to explore emerging models of episode-based payments, physician-hospital organizations and physician bonus structures.

On April 29, 2011, our healthcare industry changed forever

- Centers for Medicare and Medicaid Services (CMS) released its Hospital Value-Based Purchasing (VBP), required under the Patient Protection and Affordable Care Act.

- CMS continues to raise the bar on quality and patient perception of care, making it critical for organizations to have a foundation in place that can withstand the even tougher ones waiting in the future.

On April 29, 2011, our healthcare industry changed forever

Simply maintaining results is not enough.

The relationship between the quality of the patient experience of care and Value-Based Purchasing reimbursement bonuses or penalties, and between the quality of the patient experience of care and excess readmission penalties.

Population Health Management

The health outcomes of a group of individuals, including the distribution of such outcomes within the group”

- 2050, US Projection Above 65 yrs is Over 88 million
- 75% of our healthcare dollars is spent on chronic conditions, 80% preventable

Population Health Management

- Patients have need to be empowered rather than encourage their dependence on systems to provide them cures
- Patients have never been encouraged to think of their disease as their personal responsibility

What is the least utilized resource in Ameri
The Patient!

Triple Aim

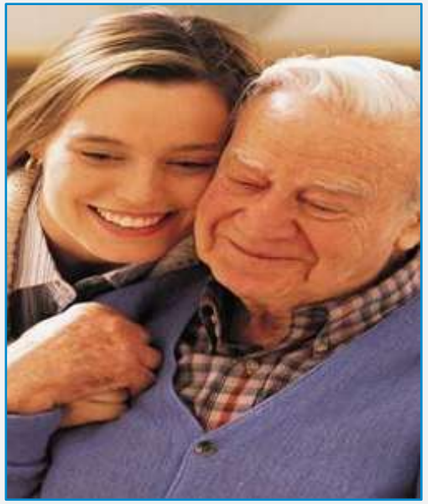
Better Health

Better Quality Care
Decrease Re-Hospitalizations

Better Health Care

Competent Staff

Reduce Costs



Satisfaction

Background

- Since 2006, legislation has called for value-based purchasing (VBP) to transform Medicare from a passive payer to an active purchaser by using specific performance measures aimed at improving quality and reducing overall costs.
- Fee for Service is going to Value Based Payment
- Participation in CMS' incentive plans have been voluntary
  - Until now, CMS is phasing in payment adjustments for non-participation
- Value-based purchasing involves three major elements for physicians:
  - Confidential feedback on performance and resource use
  - Public Reporting
  - Payment adjustment/value modifier

Healthcare's value-based reality has changed the rules of organizational alignment. Today, emerging payment models like accountable care organizations (ACOs), bundled payments and shared savings encourage hospitals and physicians to work together and make each more accountable for the other's actions.

Value Based Purchasing at a Glance Hospitals

	Value Based Purchasing	Hospital Acquired Condition
2013	1%	0%
2014	1.25%	0%
2015		
2016		

Hospital Readmission Reduction Program

Year One

- CHF, AMI, PNA
- 1% Penalty
- Medicare Penalties 280 million

Year Two

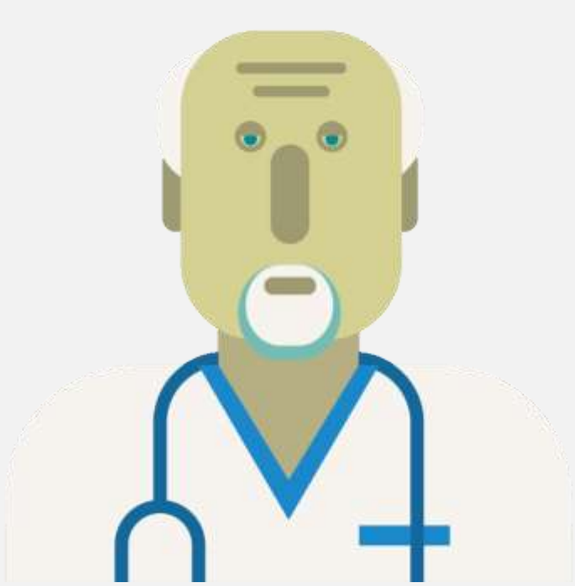
- CHF, AMI, PNA
- 2% Penalty
- 19% - 17.8% 70,000 Fewer Readmits
- 2,225 Hospitals
- 227 million Medicare Penalties

Year Three

- CHF, AMI, PNA
- COPD
- Total Hips
- Total Knees
- 3% Penalty
- 2,610 Hospitals
- 428 million in Medicare Penalties

CMS Hospital Initiative - HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems



Value Based Purchasing at a Glance Nursing Homes

www.nhqualitycampaign.org

MEDICARE SHARED SAVINGS PROGRAM (SHARED SAVINGS PROGRAM) ALIGNMENT WITH PQRS

- ACOs will report the ACO GPRO measures through a
- CMS web interface on behalf of eligible professionals and
- must meet the criteria for the 2014 PQRS incentive to
- satisfactorily report to avoid the 2016 PQRS payment adjustment.

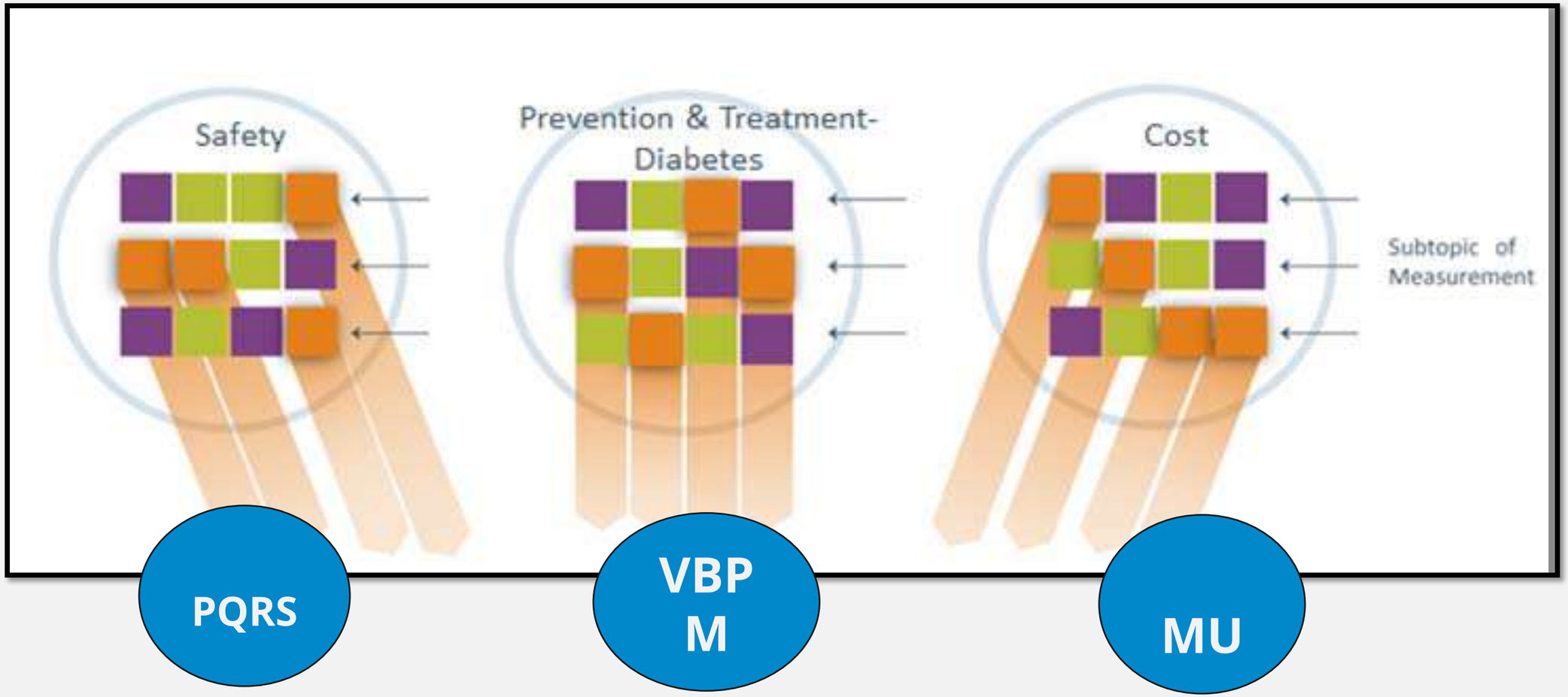
CMS Value Based Purchasing

- Overview
- Physician Quality Reporting System
- Medicare EHR Incentive Program
- Physician Compare Website
- Benchmarking
- Physician Value-Based Payment Modifier
- Physician Feedback Program
- Value modifier for items and services paid under the PFS
- PFS Physician Fee Schedule

Shared Accountability

Hospitals – SNF – ALF – HH – Practitioners - Health Plans - Patients

Core Measures



Payors on all levels

- Federal level - state level - commercial insurers - self-insured employers stabilizing cost growth - shift risk from themselves to providers
- Incentives for providers – opportunities are everywhere!
- Physicians are eligible for bonus payments
- Using Measures from clinical and quality
- Prescribing habits, Access to care and Levels of technology used Newly development and improved
- Best Practice evidence based quality improvement projects

Align performance measurement across programs and sectors to provide consistent and meaningful information

2014 - 2016

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

T I M E L I N E

MILESTONE DATES

2014

- January 1, 2014
- January 27, 2014
- January 31, 2014
- February 28, 2014
- March 21, 2014
- March 31, 2014
- April 1, 2014
- September 30, 2014
- November 1, 2014
- December 31, 2014

2015

- February 27, 2015
- February 28, 2015
- December 31, 2015

2016

- February 26, 2016
- February 28, 2016
- December 31, 2016

Why PQRS

- Physician Quality Reporting System
- Gives participating EPs the opportunity to assess the quality of care
- They are providing to their patients,
- Helping to ensure that patients get the right care at the right time.
- By reporting PQRS quality measures, providers also can quantify how often they are meeting a particular quality metric.
- Using the feedback report provided by CMS, EPs can compare

PQRS
Affects payments to certain groups of MDs based on quality and cost of care

Eligible Professionals

- Under Physician Quality Reporting System (PQRS), covered professional services are those paid under or based on the Medicare Physician Fee Schedule (PFS).
- To the extent that eligible professionals are providing services which get paid under or based on the PFS, those services are eligible for PQRS incentive payments and/or payment adjustments.

Medicare Physicians

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- 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
- Registered Dietician
- Nutrition Professional
- Audiologists
- **Includes Advanced Practice Registered Nurse (APRN)*

Therapists

- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist

Public Reporting-Physician Compare

- Physician Compare is a CMS Website for publicly reporting physician performance;
    - Hospital Compare
    - Nursing Home Compare
- Physician Compare currently reports
    - Physician has satisfactorily reported quality measures through PQRS
    - That a physician received a bonus for electronic prescribing
    - That a physician group participated in PQRS using the GPRO Group Practice Reporting Option

CMS will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported.

Confidential Feedback on Performance and Resource Use

Quality and Resource Use Reports (QRURs)

- EPs who report PQRS quality measures data can request to receive National

  Provider Identifier (NPI)-level Physician Quality Reporting Feedback Reports.
- Provide comparative information so physicians can view the clinical care their patients receive, average care and costs of other physician's Medicare patients
- This was intended as a precursor to the VBM and currently includes cost of care measures for patients seen by the physician and quality information calculated using claims data from PQRS
- The reports include information on reporting rates, clinical performance, and incentives earned by participating individual professionals, with summary information on reporting success and incentives earned at the practice level.

Incentive Payments

- Individual EPs who meet the criteria for satisfactory submission of PQRS quality measures data via one of the reporting mechanisms above for services furnished during the 2014 reporting period will qualify to earn an incentive payment.

- If they qualify, they will receive an incentive payment equal to 0.5% of their total estimated Medicare Part B PFS allowed charges for covered professional services furnished during that same reporting period.

Incentive Payments

Required

- Satisfactorily submitting data, without regard to method, on quality measures under PQRS, for a 12-month reporting period either as an individual physician or as a member of a selected group practice

AND

- More frequently than is required to qualify for or maintain board certification:
- Participate in a Maintenance of Certification Program and
- Successfully complete a qualified Maintenance of Certification Program practice assessment.

Payment Adjustments-PQRS

Payment adjustments for PQRS – Physician Quality Reporting System

- Has been moving from bonuses for successful participation to penalties for non-participation
- Eligible professional (EPs) who did not participate in PQRS in 2013 will receive a 1.5% payment adjustment
- EPs who do not satisfactorily report data on quality measures for covered professional services during the 2014 PQRS program year will be subject to a 2% payment adjustment to their Medicare PFS amount for services provided in 2016.

Meaningful Use

- Eligible Professionals & Hospitals
- Core Objectives
- Stages 1-3

- American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:
  - Use of a certified EHR in a meaningful manner, such as e-prescribing
  - Use of certified EHR technology for electronic exchange of health information to improve quality of health care.
  - Use of certified EHR technology to submit clinical quality and other measures.
- Payment adjustments for Meaningful Use is moving from bonuses for successful participation to penalties for non-participation
- Eligible professionals (EPs) who do not participate in Meaningful Use by 2014 will receive a 1% payment adjustment in 2015

Medicare EHR Incentive Program
We are finalizing additional options for eligible professionals (EPs) to report clinical quality measures (CQMs) under the Medicare EHR Incentive Program beginning in 2014.

E-Prescribing

- Payment adjustments for e-prescribing are moving from bonuses for successful participation to penalties for non-participation
- Eligible professionals (EPs) who didn’t participate in E-Rx in 2011 experienced a 1% payment adjustment in 2012
- 1.5% in 2013
- 2.0% in 2014

International Classification of Diseases-Tenth Revision (ICD-10-CM) Implementation

UPDATE:

With enactment of the Protecting Access to Medicare Act of 2014, CMS is examining the implications of the ICD-10 provision and will provide guidance to providers and stakeholders soon.

Summary of Final PQRS Measures

CMS is finalizing the following updates to the PQRS, In the CY 2014 PFS rule

- 57 new individual measures added and
- 2 measures groups to fill existing measure gaps and
- Plan to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms
- PQRS will contain a total of 287 measures and 25 measures groups in 2014

Value-Based Payment Modifier

In 2015, Medicare will begin providing differential payments to physicians based on quality and cost of care

- Services provided during 2013 will be used to calculate the 2015 modifier
- This modifier will also apply to payments for items and services provided in physician groups of 100 or more Eps
- The payment adjustments will range from 1%-3%
- The modifier is expected to be phased over a 2 year period with full implementation by 2017

For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group's physicians participate in the Medicare Shared Savings Program Accountable Care Organizations (ACOs), the testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative.

Value-Based Payment Modifier

In 2016, groups with 10 or more EPs who submit claims to Medicare under a single tax identification number will be subject to the value modifier, based on their performance in 2014.

- These groups will need to register and choose one of the PQRS GPRO quality reporting methods.
- If a group does not choose to report quality measures as a group, and at least 50% of the EPs within the group report PQRS measures individually, CMS will calculate a group quality score based on their reporting.
- Failing to report will result in a negative 2% value modifier adjustment to 2016 payment under the PFS. The VM adjustment is in addition to the PQRS payment adjustment.

The Value Modifier applies only to physician payments under the Medicare PFS.
The Value Modifier does not apply to payments that are NOT made under the Medicare PFS, including those for physicians providing services in Rural Health Clinics, Federally Qualified Health Centers,
and Critical Access Hospitals (CAHs) (for CAHs electing method II billing).

Value Modifier Scoring

Quality of Care Composite Score

Cost Composite Score

Value Modifier Amount

Combine each quality measure into a quality composite and each cost measure into a cost composite using the domains above.

Quality Domain Examples

PQRS Measure Examples

- Clinical Care
  - CAD - Lipid Control
- Patient Experience
  - Getting timely care, appointments and information
  - Communication from your doctor
- Patient Safety
  - Medication Reconciliation
- Care Coordination
  - Advance Care Plan
- Efficiency
  - Cardiac Stress Imaging

Reporting as an Individual Eligible Professional (EPs)

Choose your reporting mechanism

- Medicare Part B Claims
- Qualified PQRS Registry
- Direct EHR product using CEHRT-Certified Technology
- CEHRT via EHR data submission vendor
- Qualified clinical data registry (QCDR)
- You must affirmatively elect to be analyzed under this reporting mechanism

Choose your measures

- Individual Measures or Measures Groups

Reporting as a GPRO

Choose your reporting mechanism

- Qualified PQRS Registry
- Web Interface (groups 25+ only)
- Direct EHR product using CEHRT-Certified Technology
- CEHRT via EHR data submission vendor
- CG CAHPS CMS-certified survey vendor (groups 25+ only)
- You must affirmatively elect to be analyzed under this reporting mechanism

Choose your measures

- Individual Measures or Measures Groups

Selecting Measures

Quality Measures

- Are developed by provider associations, quality groups, and CMS and are used to assign a quantity, based on a standard set by the developers, to the quality of care provided by the EP or group practice
- Types of measures reported under PQRS change from year to year. The measures generally vary by specialty, and focus on areas such as care coordination, patient safety and engagement, clinical process/effectiveness, and population/public health. They can also vary by reporting method
- When selecting measures for reporting, eligible professionals should consider factors such as:
    - Clinical conditions commonly treated
    - Types of care delivered frequently – e.g., preventive, chronic, acute
    - Settings where care is often delivered – e.g., office, emergency department (ED), surgical suite
    - Quality improvement goals for 2014
    - Other quality reporting programs in use or being considered

Quality Measures Count Updates

Totals 2014	2013	Final
Measures	258	284
Measures Removed	N/A	45

Quality Measures

Conditions that contribute, represent, are common to morbidity and mortality of most Medicare and Medicaid beneficiaries

National Public Health priorities of conditions that drive healthcare costs

Submission Method Count Update

Submission Method Counts	2013	2014
Claims Measures	137	110
Qualified Registry Measures	203	201
EHR Measures	51	64
GPRO Web Interface Measures 22	22 (Includes subcomponents of composite measures)	
CMS-Certified Survey Vendor for PQRS	N/A	CAHPS
(12 Summary Survey Modules) Measures Groups	22	25

Patient Experience of Care Survey CG-CAHPS

- CMS will fund and administer the survey on behalf of the groups participating in the GPRO Web Interface
- Clinician-Group Consumer Assessment of Health Plans and Systems Survey
- CG-CAHPS Measures
  - Getting timely care, appointments and information
  - How well your doctors communicate
  - Patients rating of doctor
  - Access to Specialists
  - Health promotion and education
  - Shared decision making
  - Courteous and helpful office staff
  - Care coordination
  - Between visit communication
  - Educating patients about medication adherence
  - Stewardship of patient resources

Coronary Artery Disease (CAD) Measures Group

- Coronary Artery Disease
- (CAD) Measures Group
  - Coronary Artery Disease (CAD): Antiplatelet Therapy
  - Coronary Artery Disease (CAD): Lipid Control
  - Preventative Care and Screening: Tobacco Use:
  - Screening and Cessation Intervention
  - Coronary Artery Disease (CAD): Symptom Management

Benchmarking

- CMS indicated that we would use national Medicare Advantage data, national FFS Medicare data or a flat percentage to establish the quality performance benchmarks for the Shared Savings Program, and would seek to incorporate actual ACO performance into establishing quality benchmarks in future program years.

- Finalizing proposals to use fee-for-service data, including data submitted by Shared Savings Program and Pioneer ACOs, to set the performance benchmarks for the 2014 and subsequent reporting periods.

Benchmarking

- CMS did not finalize the proposal to use MA data alone or in combination with fee-for-service data in the short-term to set ACO performance benchmarks.
- CMS will set benchmarks based on flat percentages when the 60th percentile is equal to or greater than 80.0 percent.
- Finalizing our proposal to increase the scoring for the CG CAHPs survey measure modules within the patient experience of care domain that transition to pay-for-performance in the second year of an ACO's agreement period, so that these CAHPS survey measure modules will carry greater weight within the patient experience of care domain.
- The weight of some measure modules within the domain will increase, the domain itself will continue to represent 25% of the total quality performance score.

New Care Delivery Initiatives

- Patient Centered Care
- Accountable Care Organizations
- Managed Medicaid programs
- Different types of bundling payments utilizing evidenced based systems
- Transparency
- Affordable Care Act
- CMS' Core Measures

"By eliminating stumbling blocks and red tape we can assure that the health care that reaches patients is more timely, that it's the right treatment for the right patient, and greater efficiency improves patient care across the board," said CMS Administrator Marilyn Tavenner.

http://en.wikipedia.org/wiki/Marilyn_Tavenner

Opportunities for Quality Care Improvement

As industry leaders, identify areas that will advance value based care, develop systems that focus on quality and puts patients at the center of our focus, while maximizing revenues.

Value is added… when residents, patients and families are happy and satisfied with the care

Walmart Care Clinics
$40 for visit
$ 4.00 for employees
Open 12 hours a day

Lower Costs, Better Care: Reforming Our Health Care Delivery System, Spending slowing, Health Outcomes Improving
Adverse Events decreasing, Patients engaged, shopping for coverage Paying for value and continuous quality assurance and improvement

New Care Delivery Model

Clinics / Ambulatory

General Practitioner

Patient's Needs: Holistic Approach for Transition

Patient Holistic Approach

Cultural Factors:
- Dignity
- Religions
- Respect
- Specific Language
- Education/Information
- Tools-Effective

Psychosocial:
- Advance Directives
- Mental Health
- Social Functioning
- Depression
- Cognitive Impairment

Financial Factors:
- Insurance benefits
- Financial resources
- Financial impact of treatment

Physiological:
- Diagnosis
- Medical follow up
- Prognosis
- Symptoms
- Treatment options

Spiritual Factors:
- Values
- Support System

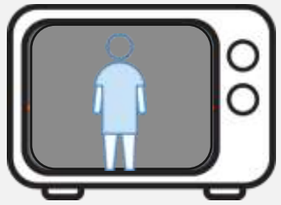
Community Resources:
- Meals
- Medication Assistance

Environmental factors:
- Electric
- Safety
- Meals
- Lawn/ Garden.

Beneficiary:
- Promote informed decision making
- Educational support- ability- how learn
- Right to privacy & confidentiality
- Treat with Respect
- Dignity with cultural, religious, socioeconomic, & diversity
- Participate and understand the plan & care
- Activities of Daily Living - level of care needed
- Assessment
- Informed consent

Coordination:
- Interdisciplinary Team
- Professionals (other)
- Specific Clinical Providers

Family Factors:
- Indentify assistance can provide
- Affects others
- Educational support
- Evaluate psychosocial needs



X-Ray

Specialty Physicians

Physiotherapy

Pharmacy

Hospitals / Health Systems

Home

Assisted Living

Rehab Services

Skilled Nursing Facilities

Multiple Delivery Settings

Integrated Patient Delivery Model

Primary Care Physician

Who needs to use Technology?
The ENTIRE Health Care System

- Accountable Care
- Organizations,
- Rural Hospitals
- Insurance Companies

Hospital

IMPACT Act

Why they need to address?

- Readmissions
- Value Based Purchasing
- Chronic Disease
- Management
- New Patient Centered Care Models

Facility Clinical Team

Who Benefits?

- Patients, Families, Physicians
- Our Entire Healthcare System

Patient & Family

Medicare Reimbursement for Transitional Care and Chronic Care Management

- Transitional CPT Codes
- Medicare began reimbursing for transtional care services January 1, 2013
- This is the first time in history that Medicare has decided to directly and specifically reimburse a separate care coordination service
- CCM Codes

Success in healthcare is a puzzle

Every piece matters

Donald M. Berwick, MD, MPP

Former President and CEO

Institute for Healthcare Improvement

“The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.“

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THANK YOU !