Clinical Quality Reporting: Value Modifier

General Internal Medicine Grand Rounds
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Future Payment Will Be Impacted by More than Just Changes to the Medicare Provider Fee Schedule

2013 PQRS Incentive +0.5%

2013 EHR Incentive or eRx Incentive

2013 Calendar Year Data

MOC +0.5%

2014 E-RX Penalty

• Last opportunity to avoid 2014 2% reduction

2015 PQRS Penalty - 1.5%

• 1.5% reduction at the NPI if not successful reporting PQRS measures

2015 EHR Penalty

• 1% reduction at NPI level
• Additional 1% reduction if not successful e-prescriber in 2014
• Attest for MU in 2013

Value Modifier

• 1% reduction to TIN
Program overview – Physician Quality Reporting System: reporting of clinical quality metrics, introduce providers to quality submission - CMS

- Inception 2007: evolving/expanding measures
- Reporting program only
- Limited feedback data
- Participation is currently publicly reported
- PQRS reporting merges with other quality reporting 2014 – 2016
- Migration from an incentive program to payment adjustment program
  - Incentive amounts are:
    - 2012: +0.5%
    - 2013: +0.5%
    - 2014: +0.5%
  - Payment adjustment amounts are:
    - applied to the individual physician Medicare Fee Schedule
    - 2015: -1.5% (based on 2013 submission
    - 2016 and each subsequent year: -2.0%
PQRS Performance Record

- 2007
  - Individual provider claim submission
  - Minimal success
  - Revenue $8K

- 2008
  - Combination individual provider and limited CINA registry
  - CINA extracts and submits at the individual provider level
    - Revenue $32K

- 2009
  - Combination individual provider and expanded CINA registry
    (submission is UPI admin expense)
    - Revenue approx $83K

- 2010 – 2012
  - CINA Registry submission with minimal individual provider submission
  - $120K → $240K → TBD submission in progress
PQRS Performance Record

- Lessons learned
  - Successful extraction relies on data existing as a discrete value
  - Successful extraction relies on data existing in defined areas of the record
  - Increased financial earnings results from an extended EHR platform
  - Clinical leadership selected measures annually but in most areas this did not translate to more “robust” quality reporting at a clinical unit level
    - Documentation was not standardized or created in a defined area for extraction
    - Lack of widespread provider awareness and adoption of measures
    - Lack of system/smart based prompts
E-Prescribe

Program overview: incent electronic prescribing to decrease medication errors

- Program inception 2011
- An incentive program and a payment adjustment program from the beginning
  - Incentives:
    - 2010: +2.0%
    - 2011: +1.0%
    - 2012: +1.0%
    - 2013: +0.5%

- Payment adjustments: 2 year look back
  - applied to the individual physician Medicare Fee Schedule
    - 2012: -1.0%
    - 2013: -1.5%
    - 2014: -2.0%
    - 2015: NA
E-RX Performance

2010 – 2012

- Some penalties incurred (lack of fully implemented EHR)
- Provider claims submission in 2010
- 2011→2012 CINA registry submission for the individual provider
- 2012 successful MU attestation avoids the 2014 penalty
  - Participation in MU prevents a provider from earning a separate e-RX incentive payment
- Incentive earnings:
  - 2010: $3K (submitted via claims)
  - 2011: $120K
  - 2012: $TBD
Value Based Modifier Basics

- The first program to assess quality and cost with a direct impact (+ $ or -$) to the Medicare physician Fee Schedule
  - The + or – can change annually based on cost/performance
  - Successful completion of reporting in 2013 avoids the VM penalty for 2013 ONLY (0% impact to TIN MC)
- Goal is to encourage shared responsibility and system based care
- Aligns with PQRS reporting initially, converges with MU Quality Measures in 2014
  - aligns efficiency of reporting quality measures
  - Narrows the focus of quality reporting efforts across the adult clinical enterprise
Value Based Modifier Basics

• What this means for UPI CINA registry submission
  – Individual CINA registry PQRS submission for CY 2013
    • Earns the PQRS + 0.5% incentive
    • Avoids the PQRS -1.5% penalty
    • UPI still incurs the -1% VM penalty
  – UPI will submit as a Group (Group Reporting Option = GPRO) to avoid the Value Modifier penalty
    • UPI Admin will no longer support CINA for PQRS individual registry submission
      – Successful UPI submission of the VM report in 2013 avoid VM penalty at the tax ID (0%)
      – Earns PQRS 0.5% PQRS incentive
      – Avoids PQRS -1.5% penalty
  • UPI admin will be responsible for data extraction and submission in the VM program
Value Based Modifier Basics

- Initial application to large physician groups > 100 NPI in 2015 (applicable to UPI/SOM)
  - All groups in 2017, meaning smaller practices will not be “in tune” with the impact of the program until 2015 and later
- Performance period for 2015 VM is CY 2013 (applies a 2 yr look back)
  - Yr 1: complete the reporting exercise first quarter 2014, the VM penalty = 0%, quality tiering for + or – is voluntary
  - Failure to report in Yr 1 → -1% reduction at the TIN in 2015
    - Based on CY 2012 MC collection ~ $325K
  - Yr 1 reporting data is generated by encounters in 2013
  - Yr 2 quality tiering is mandatory → +2% to -1% at the TIN
- Program is budget neutral
  - Their must be “winners” and “losers”
  - In 2015 and 2016 UPI/SOM will be cost/quality compared to other large academic medical centers
Value Based Modifier Basics

- CMS provides detailed feedback reports on quality performance and all costs
- Program performance is publicly reported
  - UPI/SOM already publicly reported for PQRS
  - Details on subsequent slides
- Applies to all providers who submit claims via UPI
- **Penalty assigned at the TIN level**, unlike PQRS, MU, E-RX, where penalty applied at the **individual** NPI level
  - Any provider who joins UPI/SOM and bills Medicare will be subject to the + or – applied to the group in 2015 and beyond
  - The + or – is updated annually based on cost/quality performance
2 Step Attribution

- Retrospective assignment
- Medicare = primary payer
  - excludes Medicare Advantage
- Based on MC claims beginning 1/1/13 and processed by 10/25/13 (10 months)
- Assigns at the Group level based on:
  - Plurality of E&M primary care visits; THEN
  - Plurality of E&M specialty care if no primary care
  - Primary care = FM, GIM, Geriatrics ONLY
  - Specialty care = all others
  - Patients attributed at the specialty care level can be assigned to quality modules unrelated to the nature of the specialty visits, ie oncology patients attributed to DM module
  - Eligible visits are: ambulatory visits, nursing facility visits, home visits
    - Does not assign attribution on surgical/procedural codes, diagnostic codes, ED codes, inpatient codes
- 411 consecutive patients reported in every VM Quality module
- Patients are unaware of attribution, invisible to the patient
  - No penalties at the patient level for personal behavior that drives cost, impacts quality
UPI PCP Attribution: Model 1

- Where is the patient’s attribution:
  - UPI PCP (Albertson = 5 > Community PCP = 2)

- What is UPI required to report?
  - DM, HTN, CAD, COPD or any patient dx that is applicable to the patient and the patient’s assigned VM quality module

- What will UPI be measured on?
  - All VM quality measures applicable to the attributed patient
    - Includes COPD measures where care managed by the community pulmonologist
  - All patient costs (includes the community “generated” provider costs, UPI specialty costs)
  - Reminder: the community (specialty and PCP) are immune/unaware to the program until 2017

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of visits</th>
<th>Pt DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albertson PCP</td>
<td>5</td>
<td>DM, HTN, CAD, COPD</td>
</tr>
<tr>
<td>Finlayson Surg</td>
<td>3</td>
<td>Breast CA</td>
</tr>
<tr>
<td>Community Pulmonologist</td>
<td>3</td>
<td>COPD</td>
</tr>
<tr>
<td>Community PCP</td>
<td>2</td>
<td>URI, HTN</td>
</tr>
<tr>
<td>Community Specialist - Oncology</td>
<td>5</td>
<td>Breast CA</td>
</tr>
</tbody>
</table>
Community PCP Attribution: Model 2

- Where is the patient’s attribution:
  - Community PCP = 2

- What is UPI required to report in the VM program?
  - Nothing

- What will UPI be measured on?
  - Nothing, BUT we are now measured costs to the community
  - In 2017 the community provider will be measured on all patient costs and quality (includes the costs and quality metrics managed/generated by UPI specialists, community specialists)

<table>
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<tr>
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<th>Number of visits</th>
<th>Pt DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology Borges</td>
<td>5</td>
<td>Breast CA</td>
</tr>
<tr>
<td>Finlayson Surg</td>
<td>3</td>
<td>Breast CA</td>
</tr>
<tr>
<td>Community PCP</td>
<td>2</td>
<td>DM, HTN, CAD, COPD</td>
</tr>
<tr>
<td>Community pulmonologist</td>
<td>3</td>
<td>COPD</td>
</tr>
</tbody>
</table>
Specialist Attribution: Model 3

- Where is the patient’s attribution:
  - UPI Specialty Oncology Borges
    - 4 visits – patient assigned by the plurality of specialist visits
    - no PCP encounters either internal or external

- What is the UPI specialist required to report?
  - DM, HTN, CAD, or any patient dx (whether we coded it or not) that is applicable to the patient dx and the VM quality module. Assignment to a VM quality module is INDEPENDENT of the type of specialist

- What will the UPI specialist be measured on?
  - All quality measures defined in the VM program applicable to the attributed patient – DM, HTN, CAD
  - All Patient costs (includes the costs generated by the community specialists)
  - Community specialists unaware of program until 2017

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<tr>
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<th>Number of Visits</th>
<th>Pt DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albertson PCP</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Oncology Borges</td>
<td>4</td>
<td>Breast CA</td>
</tr>
<tr>
<td>Finlayson Surg</td>
<td>2</td>
<td>Breast CA</td>
</tr>
<tr>
<td>Community Endocrinologist</td>
<td>3</td>
<td>DM</td>
</tr>
<tr>
<td>Community PCP</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Community Specialist Cardiology</td>
<td>3</td>
<td>CAD, HTN</td>
</tr>
</tbody>
</table>
Quality-Tiering Methodology

The following domains are used to report and combine each quality measure into a quality composite score. (Similar domains used in ACO and MU)

- Clinical care
- Patient experience
- Population/Community Health
- Patient safety
- Care Coordination
- Efficiency

Quality of Care Composite Score

Cost Composite Score

VALUE MODIFIER AMOUNT
<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>GPRO Module</th>
<th>GPRO Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Process/Effectiveness (11 Measures)</td>
<td>Diabetes Mellitus</td>
<td>• HbA1C Poor Control</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td>• Diabetes Composite: Optimal Diabetes Care</td>
</tr>
<tr>
<td></td>
<td>Preventative Care</td>
<td>• Beta Blocker Therapy for LVSD</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease</td>
<td>• Pneumonia Vaccination Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Breast Cancer Screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Colorectal Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Ischemic Vascular Disease</td>
<td>• ACE/ARB Therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lipid Control</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>• Use of Aspirin or Another Antithrombotic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complete Lipid Panel and LDL Control</td>
</tr>
<tr>
<td>Patient Safety (2 measures)</td>
<td>Care Coordination/Patient Safety</td>
<td>• Medication Reconciliation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Screening for Fall Risk</td>
</tr>
<tr>
<td>Population/Public Health (5 measures)</td>
<td>Preventative Care</td>
<td>• Influenza Immunization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adult Weight Screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Screening for Clinical Depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td></td>
<td>Claims-based outcome measures (CMS)</td>
<td>• Composite of Acute PQIs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Composite of Chronic PQIs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All-cause readmission</td>
</tr>
</tbody>
</table>
VM Quality of Care Calculated Outcome Measures - Details

- All cause hospital readmission – 30 days
- Follow up after hospital discharge – 30 days
- Composite of Acute Prevention Quality Indicators: medical conditions for which timely and coordinated outpatient care can potentially prevent the need for hospitalization. Measure looks at hospital discharge data
  - Acute Condition Composite
    - Bacterial Pneumonia
    - UTI
    - Dehydration
  - DM
  - COPD or Asthma
  - Heart Failure
- Composite of Chronic Prevention Quality Indicators: medical conditions for which timely and coordinated outpatient care can potentially prevent the need for hospitalization. Measure looks at hospital discharge data, ED visits
  - COPD
  - Diabetes Composite
    - Uncontrolled Diabetes
    - Short Term Diabetes Complications
    - Long Term Diabetes Complications
    - Lower Extremity amputation for Diabetes
VM Quality Scores - Details

• **Diabetes Composite Score – All or Nothing**
  – Blood pressure control
  – LDL < 100
  – A1C < 8.0%
  – Daily Aspirin or Antiplatelet medication use for patients with Diabetes and Ischemic Vascular Disease
  – Tobacco Non-Use

• **Quality of Care Composite Scoring**
  • Quality scores standardized and compared to National Benchmark
    • Risk adjusters are applied based on patient dx
  – Individual measures roll up into domains
  – Domains weighted equally
  – Minimum of 20 patients to be included in scoring
  – Attributed providers placed in categories: high, average, low cost and quality
VM Total Cost Scoring

Cost Scores

- Cost scores are price standardized and risk adjusted (CMS HCC risk) to accommodate for differences in cost resulting from circumstances beyond physician control
  - Geographic variation in cost is eliminated, variable labor costs and PE eliminated

- Costs exclude:
  - IME/GME dollars
  - Part D medications
  - DSH

- Costs include:
  - All Medicare Part A
  - All Medicare Part B
  - Injectable Part B medications
  - “Real” expenses related to place of service, type of provider, multiple services in 1 setting
    - Facility based vs non-facility based fees do generate cost differences
VM Cost Scoring for Beneficiaries with Special conditions

• 4 chronic health conditions measured
  – DM, COPD, CHF, CAD
  – Subgroup per capita costs include all costs, not just those associated with the condition
Methodology for Developing Standardized Scores for Quality Measures

<table>
<thead>
<tr>
<th>Quality measure</th>
<th>Individual Group Performance Score</th>
<th>Benchmark (National Mean)</th>
<th>Individual Group Score Minus Benchmark</th>
<th>Standard Deviation</th>
<th>Standardized Score (Diff/St Dev)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>95.0%</td>
<td>93.5%</td>
<td>1.5</td>
<td>3.3%</td>
<td>+0.47</td>
</tr>
<tr>
<td>Measure 2</td>
<td>71.4%</td>
<td>86.3%</td>
<td>-14.9</td>
<td>13.9%</td>
<td>-1.07</td>
</tr>
<tr>
<td>Measure 3</td>
<td>100.0%</td>
<td>60.6%</td>
<td>39.4</td>
<td>13.2%</td>
<td>+2.98</td>
</tr>
<tr>
<td>Domain Score (average std score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.79</td>
</tr>
</tbody>
</table>
### Quality Tiering Payment

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>2.0x*</td>
<td>1.0x*</td>
<td>0.0%</td>
</tr>
<tr>
<td>Average Quality</td>
<td>1.0x*</td>
<td>0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

*cells eligible for high risk bonus

- Maximum reduction is -1.0% for low quality and high cost
- Payments are budget neutral; positive adjustment ("x") will be after performance period ends (and CMS knows the total deductions)
- Additional “1.0x” for high risk patients (average beneficiary score in top 25%)
  - High risk adjustment only applies if score is:
    - High quality/low cost
    - High quality/average cost
    - Average quality/low cost
Public Reporting

- CMS “push” to get patients directed to Quality providers
- PQRS Public Reporting already occurring based on CINA PQRS submission
- Data posted on Physician Compare starting in 2014, data based on 2013 and forward
- CMS will administer and pay for CG-CAHPS survey for 2013 and 2014 GRP Web participants
  - Getting timely care, appointments and Information
  - How well your doctors communicate
  - Patient’s rating of Doctor
  - Access to specialists
  - Health Promotion and Education
  - Shared Decision-making
Where to start

• UPI is modeling attribution now
  – Analyze where we are at risk for attribution – Specialists
    • What data do we have for VM conditions
    • Understand PCP relationship – who is it, where is it, does it exist?
    • Understand how to interact with PCP’s – data collection, data sharing, coordinating care

• Centralize UPI Admin resources responsible for program reporting, data extraction

• Data Extraction
  – What do we have, what is missing that impacts quality scores in VM domains, how do we get the extra data?
  – Some chart abstraction will likely be required
Where to start

• Review quality initiatives and overlap with VM quality reporting
  – Discharge summaries
  – External PCP communication strategies
  – MU Quality Indicators
  – MOC initiatives
• How does this program impact
  – Clinical documentation – can we extract the data for reporting?
  – Enterprise agreement on clinical algorithms
  – Epic Best Practice Alerts
    • How can we leverage the EMR?
  – Roles for other staff members (Kaiser model)
• Discuss how existing population health programs can/should be leveraged
  – Ambulatory Health Promotion
  – UPI Health Plan Development services (CU Cigna)
  – Case Management services servicing Enterprise attributed patients
Where to start

• Discuss implications for our internal Primary Care Providers
• Explore enhanced analytic services to inform care
• Discuss how we can educate Medicare patients about their role in this program
  – Investment in medical home
  – Awareness of cost
  – Awareness of quality
• Discuss how we educate community based providers on this program
• Discuss how we create “awareness” of potential avoidable costs, any cost
• Discuss how we support essential services with “limited” patient contact
• Other
Questions and Comments