CRASH 2016: Update on Governmental Action in Health Care

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- No conflicts of interest to disclose
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Objectives
- Provide updates on governmental action at the federal level affecting health care delivery and payment for anesthesia services
- Understand how the American Society of Anesthesiologists is responding to the challenges created by health care reform
- Learn what you can do at the group, department, and individual level to prepare for future challenges

#10 – How is ASA Organized to Address the Challenges?
# ACA Implementation

- Accountable Care Organizations (ACO) and other implementations now with 2-5 years of experience
- Health Care Exchanges under stress (12 of 23 co-ops have failed, large insurers are losing money)
- Medicaid expansions stabilizing (maybe)
- Major changes to provider payments now through 2017 (and beyond) through PQRS and the Value Modifier (VM)
Alternative Payment Methodologies

- Capitation
- Bundled payments
- Co-management agreements
- Accountable care organizations/population management
- Full economic integration between hospitals and providers/global payment
- *Governmental integration of hospitals and providers

*Not typically mentioned

Progress Towards Achieving Better Care, Smarter Spending, Healthier People

By: Sylvia Mathews Burwell, HHS Secretary

Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.
Physician Quality Reporting System

- Started in 2007 as PQRI
- Morphed into Physician Quality Reporting System (PQRS)
- For 2012 – 2014 it was structured as an incentive for reporting performance of certain measures
- Now requires demonstrated performance (what a concept but harder than it sounds!)

CMS PQRS Penalties 2012-2017

<table>
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<tr>
<th>Year</th>
<th>eRx</th>
<th>EMR</th>
<th>PQRS</th>
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<tbody>
<tr>
<td>2012</td>
<td>+1.0%</td>
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<tr>
<td>2014</td>
<td>-2.0%</td>
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<td>No penalty</td>
</tr>
<tr>
<td>2015</td>
<td>No penalty</td>
<td>-1.0%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2016</td>
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<tr>
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<td>No penalty</td>
<td>-3.0%</td>
<td>-2.0%</td>
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Note: Data for 2017 is for 2017 and beyond.

Sources: 2012 Medicare physician fee schedule; Medicare and Medicaid EHR Incentive Program Basics, Centers for Medicare & Medicaid Services

Previous Anesthesia Performance Measures

- #30 – Timing of prophylactic antibiotic (now retired)
- #76 – Prevention of Catheter-Related Bloodstream Infections (CRBSI)
- #193 – Perioperative Temperature Management
National Quality Strategy (NQS)

The Six 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

ASA Committee on Performance and Outcomes Measures

- Develop and validate performance and outcomes measures
- Submit to ASA House of Delegates for approval
- Works with the Anesthesia Quality Institute for QCDR based measures
- Formal PQRS measures are then referred for evaluation by the National Quality Forum

#6 – How is PQRS Changing?
2016 PQRS Performance Measures

- #44 CABG Beta Blocker Therapy
- #76 Prevention of CVC Related Blood Stream Infections
- #109 Osteoarthritis Pain and Function Assessment
- #130 Documentation of Current Medications
- #131 Pain Assessment and Follow Up
- #193 Perioperative Temperature Management
- #226 Preventive Care and Screening – Tobacco Use
- #342 Pain Brought Under Control Within 48 Hours
- #358 Patient Centered Surgical Risk Assessment

ASA-Proposed New PQRS Measures

- Use of checklist for direct transfer of care from anesthetizing location to critical care unit
- Prevention of PONV in adults
- Maintenance of intraoperative normothermia
- Inquiring about preoperative use of aspirin for patients with coronary artery stents
- Obstetric anesthesia measures

PQRS Reporting Mechanisms

- Claims based reporting
- Group Practice Reporting Option (GPRO) web interface
- CMS-certified survey vendor
- Qualified electronic health records
- Traditional qualified registries
- Qualified Clinical Data Registry reporting

Donald Berwick in 2016

Berwick: Over the past 20 years, as evidence grew about defects in care, there was sense of alarm. The reaction was to try to turn the lights on, to increase knowledge about the performance of healthcare in many, many dimensions for many people.

As a result, we began a festival of measurement, an almost measurement mania, where we began to believe that the solution to performance was transparency and measurement. I'm a complete fan of transparency, but we've overshot.

Now, the number of metrics exceeds the ability of any reasonable human being to consume usefully. And, there has been insufficient diligence about the alignment and harmonization of measures.

Tinker Ready, for HealthLeaders Media, January 7, 2016
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Anesthesia Quality Institute – National Anesthesia Clinical Outcomes Registry

- Received designation as a Qualified Clinical Data Registry in 2014
- Allows AQI to specify the outcomes to be measured without complicated NQF process
- Easily incorporated into other AQI claims reporting
- Simplifies VM reporting to CMS
Update on Governmental Action in Healthcare

Clark, Randall, MD

ASA QCDR: Measures that matter

The American Society of Anesthesiologists (ASA), through its affiliate, Anesthesia Quality Institute (AQI), has developed a meaningful way for providers to measure their performance in the field of anesthesiology. The ASA QCDR (Quality and Care for Desire Outcomes Reporting) is a tool designed to standardize the way data is received and analyzed. This allows for a more accurate and comprehensive understanding of patient outcomes.

- $10 million since start in 2008
- $1.6 million in 2015 redesign (in order to move from startup to mature organization)
- Currently receiving $1.4 million per year in fees
- Contract signed in October 2015 with ArborMetrix
- Will now standardize the way data is received
- Will improve data integrity
- Should provide tremendous ability to scale up programs

AQL 2.0

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Update on Governmental Action in Healthcare

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2016 Physician Quality Reporting System (PQRS)

Measure Specification and Measure Flow Guide for Claims and Registry Reporting of Individual Measures

Utilized by Individual Eligible Professionals for Claims and Registry Reporting and Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Reporting

Reporting Mechanism for Individual Measures to Avoid the 2018 Negative Payment Adjustment

Report on at least 9 individual measures covering 3 National Quality Strategy (NQS) domains for at least 50% of denominator eligible Medicare Part B FFS patients.

- Individual eligible professionals (EPs) (and group practices for registry reporting) that submit quality data for only 1 to 8 PQRS measures covering 3 NQS domains for at least 50% of the individual EP’s denominator eligible Medicare Part B FFS patients OR that submit data for 9 or more PQRS measures covering less than 3 domains for at least 50% of the individual EP’s Medicare Part B FFS patients eligible for each measure will be subject to Measure-Applicability Validation (MAV). (See 2016 PQRS Measure Applicability Validation (MAV) Process for Claims and Registry-Based Reporting of Individual Measures within CMS Analysis and Payment Guide)
- Measures with a 0% performance rate will not be counted
- An EP that sees at least 1 Medicare patient in a face-to-face encounter must report a minimum of 1 cross-cutting measure. (See 2016 PQRS List of Face-To-Face Encounter Codes within PQRS Measures Codes)
SGR Repeal and Medicare Provider Payment Modernization Act of 2015 (MACRA)

- SGR Repealed
- 2015 Updates
  - July – December - 0.5%
  - Further Updates
    - 2016 through 2019: 0.5%
    - 2020 through 2025: 0.0%
    - 2026 - forward: 0.5%
- APM 2026 – forward: 1%
- PQRS, VBM, EHR MU Consolidated

MIPS Payments

- Eligible Professionals (EP) performance assessment based on composite scores from 4 categories
  - Quality, Resource Use, Clinical Practice Improvement Initiatives, Meaningful Use
  - Threshold score determined by Secretary
  - EP composite score compared to threshold score
    - EP below threshold – negative MIPS payment adj
    - EP at threshold – zero MIPS payment adj
    - EP above threshold – positive MIPS payment adj
- All EPs have opportunity to avoid negative adjustment
MIPS Adjustments

- Losers – Negative Adjustments
  - 2019: Up to -4.0%
  - 2020: Up to -5.0%
  - 2021: Up to -7.0%
  - 2022: Up to -9.0%

- Winners – Positive Adjustments
  - Based on funds available from losers i.e. lots of losers means larger adjustments for winners, fewer losers means smaller adjustments for winners.

*Worst case under current PQRS, VBM, MU scenarios is approximately -11%*

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Setting and Competing Against Threshold

Year 1
- Set Threshold

Year 2
- Compete Against Threshold
- Set Threshold

Year 3
- Compete Against Threshold
- Set Threshold

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MIPS: Linear Sliding Scale

Example threshold of 50

More penalties than awards

More awards than penalties

Threshold = 50

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#3 – Perioperative Surgical Home
Initial PSH Learning Collaborative Completed

- Results in process of being collated and published
- PSH Collaborative 2.0 starting enrollment
- 3rd PSH Summit planned for June 24-26, 2016 in Chicago

Delivery Model Reform

- More than anything else, coming reform will seek to replace fee for service with payment for ‘value’
- Defining value is extraordinarily difficult
- In the absence of good policy in this area, everyone will focus on rates
- Not everyone understands that fee for service might be the correct model for some services

Alternative Payment Methodologies

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STILL A WORK IN PROGRESS

Co-Management Agreements

- Meet performance metrics based on quality and efficiency that are pre-established at the beginning of the contract
- Fixed monthly pay based on management hours worked
- Payment is to practice (“Manager”) not individual physicians (“Physician Participant”)
More Information

- ASA White Paper on Perioperative Surgical Home
- 2014 - 2016 Practice Management Conferences
- 3rd ASA PSH Meeting
- 2nd ASA Quality Meeting
- Special thanks to Zeev Kain, MD (UC Irvine), Stan Stead, MD (ASA VP Professional Affairs), and Mike Schweitzer (now managing Population Health for Premiere, Inc.)

Definition

- The population health approach is positioned as a unifying force for the entire spectrum of health system interventions -- from prevention and promotion to health protection, diagnosis, treatment and care -- and integrates and balances action between them.
- This will be the framework for all future action in government funded health care, and (IMHO) soon thereafter, all American health care.
ASA Committee on Future Models of Anesthesia Practice

- Oversaw initial roll-out of Perioperative Surgical Home
- Now studying the role of the anesthesiologist in population health management
- Recognizes the unique role of anesthesiology – the unifying factor in the care of all surgical patients
- Preparing a white paper and action plan for ASA leadership, Board of Directors, and House of Delegates

Population Health Action Plan

- Educate yourself on PSH and Population Health
- Understand what your institutions (surgical specialties, hospital, health system, academic medical center) are planning in the realm of population health
- Appoint a lead coordinator to facilitate communication with the external entities
- Participate in any discussion on how the financial pillar will be handled and how it will affect anesthesiology

Real #1 –
Vigorous information gathering and preparation, a “systems” approach to the challenges we face, and smart collective action, especially with the help of our professional societies, will position anesthesiology for future success!

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