

# Medicare Incentive Programs: Supporting Quality and Efficient Care Delivery.



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## Agenda

- Who is MPRO?
- Value driven Health Care
  - Adoption of HIT for Quality
    - ▶ HIT adoption; 8 SOW Doctor Office-Information Technology (DOQ-IT)
    - ▶ Prevention Program, 9 SOW Optimization of CCHIT certified EHRs to support reporting of clinical measures
- CMS Incentive Programs

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## Who Is MPRO?

MPRO is an independent nonprofit organization and a national leader in health care quality improvement and medical review.



MPRO serves as the federally designated quality improvement organization (QIO) for Michigan under contract with the U.S. Centers for Medicare & Medicaid Services.

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**Our Mission:**

Improving quality, safety and efficiency across the healthcare continuum



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**Quality Focus:**

- Medicare Contract
- External Quality Review
- Medicaid Contracts
- Other Contracts

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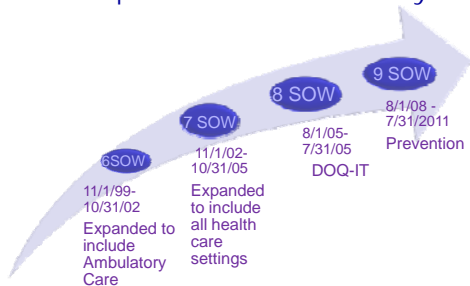
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**MPRO Scope of Work Contract Cycles**



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**MPRO**

MPRO 9<sup>th</sup> Scope of Work - Four Themes

- Beneficiary Protection 
- Patient Safety 
- Prevention 
- Care Coordination (Transitions of Care) 

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**MPRO**

The Health Care Challenge

- United States has the highest per capita spending on health care
- Wide geographic variations are present in both cost and quality
- Inconsistency in meeting evidence-based standards

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**MPRO**

Value-Based Purchasing and PQRI

Medicare's payment systems are based on

- Resource consumption
- Quantity of care, NOT quality or efficiency




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**MPRO**

**Value Based Purchasing Goal:**

**Transform Medicare from passive payer to active purchaser of high quality, efficient health care.**

**Tools:**

- QIO program
- Measurement
- Payment incentives
- Public reporting



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**MPRO**

**MPRO's Role**

- MPRO provides QI expertise, and facilitates communication with physicians and allied health professionals
- MPRO assists physicians and office staff in understanding and identifying improvement opportunities
- MPRO provides programs and quality improvement tools to act on those opportunities, including effective use of HIT
- MPRO provides assistance with reporting capabilities and sharing of information




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**MPRO**

**Doctor's Office Quality - IT (DOQ-IT)**

2005- 2008, CMS contracted with QIOs to

- Work with approximately 5% of small-to medium sized adult primary care practices in 3 domains:
- Spur adoption of HIT systems
- Improve practice workflow and capture clinical data to improve performance and patient outcomes
- Reporting of clinical quality data to data warehouse (Q-Net Exchange)

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11/4/2009

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### DOQ-IT Objectives

- Assist primary care physician practices
  - HIT adoption decision
  - HIT implementation and workflow efficiencies
  - Care management
  - Use electronic clinical data reports for improved practice performance and patient outcomes

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### DOQ-IT Results

- CMS evaluation found DOQ-IT practices exceeded expectations in using EHRs for care management
- Westat survey of DOQ-IT practices found 92% of the participating practices in Michigan were satisfied with:
  - QIO knowledge of technology options;
  - QIO ability to assess their technology needs and improve quality and efficiency of care.

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11/4/2009

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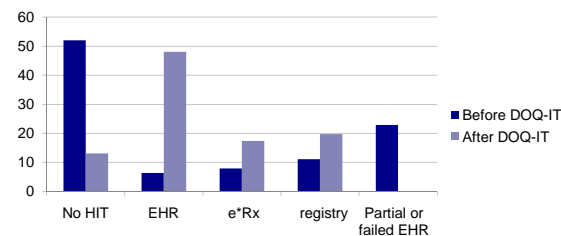
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### Percent change in HIT adoption for the DOQ-IT identified participant group



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### Value Based Purchasing Goal:

**Transform Medicare from passive payer to active purchaser of high quality, efficient health care.**

**Tools:**

- QIO program
- Measurement
- Payment incentives,
- Public reporting




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### Prevention Theme

**Purpose: To help practices efficiently use their implemented Electronic Health Records to improve preventive care rates for the following clinical topics:**

- ▶ Breast Cancer Screening
- ▶ Colorectal Screening
- ▶ Immunization (Flu/Pneumonia )




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### Core Prevention Goals

- Optimize the use of the EHR to encompass care management and patient self-management interventions for preventive services
- Improve preventive disease screening, office workflow and process re-design to support preventive care rate improvement and reporting
- Achieve relative improvement rates for mammography, colorectal screening and adult immunizations

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**Program Highlights**

- Provide a minimum of 2 hours of Care Management Education
- Assistance practices in developing Clinical Data Reports
- Implement targeted strategies to help improve screening and immunization rates.
- Consultative assistance to promote efficient office design and process improvement.
- Assistance with Physician Quality Reporting Initiative (PQRI) implementation

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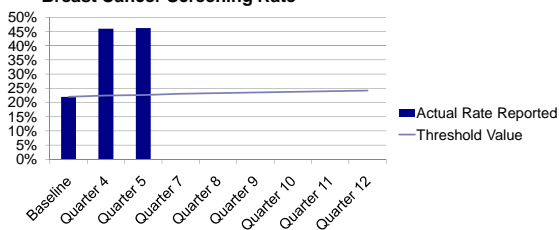
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**Breast Cancer Screening Rate**




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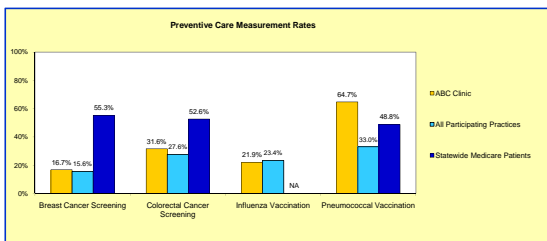
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**Reports for participating clinics**




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### Value Based Purchasing Goal:

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**Tools:**

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### Overview of Incentive Programs

- PQRI** - Physician Quality Reporting Initiative
- E-Rx** - E-prescribing (within PQRI)
- ARRA** – American Recovery and Reinvestment Act (AKA Stimulus package, HIT investment fund)

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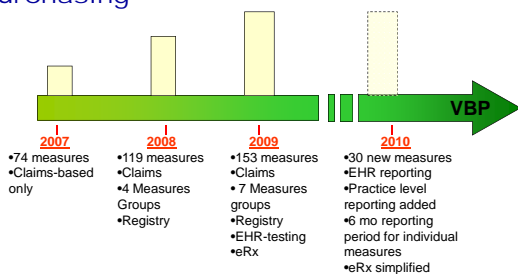
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### Towards Value-Based Purchasing



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### PQRI Quality Measures

Mechanism to allow all practices to report quality measures electronically. Measures address various aspects of quality care

- Prevention
- Chronic Care Management
- Acute Episode of Care Management
- Procedural Related Care
- Resource Utilization
- Care Coordination

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### Understanding the Measures: PQRI Quality-Data Codes (QDCs)

QDCs translate **clinical actions** for capture in claims process – they indicate that:

The measure was **met**  
– OR –

The measure was **not met** due to documented allowable performance exclusions  
– OR –

The measure was **not met** and the reason is not documented or not consistent a performance exclusion (i.e., using the 8P reporting modifier)

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### 2009 PQRI: Form & Manner of Reporting

- Quality data can be submitted for:
  - Individual Quality Measures
  - Measures Groups

- Quality data can be submitted through:
  - Claims-based submission
  - Registry-based reporting
  - NEW 2010 EHR-based reporting



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## Understanding the Measure Construct

### NUMERATOR

CPT II Code or Temporary G-code  
(describes **clinical action** required for performance)

### DENOMINATOR

ICD-9-CM & CPT Cat I Codes  
(Describes **eligible cases** for which a **clinical action** was performed; the eligible patient population as defined by denominator specification)

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## Sample Measure

### Diabetes Mellitus: Hemoglobin A1c Poor Control in

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

- Visit Code 99203
- Diagnosis code 250.00
- QDC:
  - 3046F = MOST RECENT HB LEVEL IS GREATER THAN 9.0%
  - 3045F = MOST RECENT HB LEVEL IS BETWEEN 7.0% AND 9.0%
  - 3044F = MOST RECENT HB LEVEL IS LESS THAN 7.0%
  - 3046F-8P = HB LEVEL WAS NOT PERFORMED DURING THIS PERIOD, REASON NOT SPECIFIED

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## Benefits of PQRI Participation

- Receive confidential feedback reports to support quality improvement
- Earn a bonus incentive payment
- Make an investment in the future of the practice
  - Prepare for higher bonus incentives over time
  - Prepare for pay-for-performance
  - Prepare for public reporting of performance results

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### Selection of Measures

- Consider Practice Characteristics:**
  - Clinical conditions usually treated
  - Types of care typically provided – e.g., preventive, chronic, acute
  - Settings where care is usually delivered – e.g., office, ED, surgical suite
  - Quality improvement goals for 2009
  
- Review the List of Measures:**
  
- Review 2009/10 PQRI Measures Specifications Manual for Claims and Registry & Release Notes**

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### Medicare E-Prescribing Initiative



#### E-prescribing Overview

- Established as a separate program
- Removes e-prescribing from Physician Quality Reporting Initiative (PQRI)
- Encourages use of e-prescribing through incentives and penalties
- 2009 incentive: 2% of total Medicare PartB charges
- Penalties do not start until 2012
- Names of successful e-prescribers will be publicly posted in 2010

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### Who is a Successful E-Prescriber (for 2009)?

To meet the criteria for the bonus, a provider must:

- Be an eligible professional
- Use a qualified e-prescribing system
- Report for at least 50% of the applicable encounters\*
- Have applicable encounters, as defined in the specification, account for at least 10% of his or her total Medicare Part B charges\*

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## E-prescribing: Qualified System

**A qualified system must meet all of the following :**

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers, if available.
- Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts.
- Provide information related to lower-cost, therapeutically appropriate alternatives (if any).
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

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## E-prescribing: Qualified System (continued)

**Faxing (generally) is not e-prescribing:**

"The prescription must be sent electronically. If the network converts the electronic prescription into a fax because the pharmacy can't get electronic faxes, this counts as e-prescribing.

If the e-prescribing system is only capable of sending a fax directly from the e-prescribing system to the pharmacy, the system isn't a qualified e-prescribing system." – *Medicare's Practical Guide to the E-prescribing Incentive Program*

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## E-Rx Program

- Report one of the three G-codes listed below on **more than 50% of applicable cases**
  - G8443-** used a qualified E-Rx system for **all** of prescriptions
  - G8445-** had a qualified E-Rx system, but didn't generate any prescriptions during this encounter
  - G8446-** had a qualified E-Rx system, but either prescribed narcotics/controlled substances, law requires phone or print prescription, patient asked for phone or print, pharmacy can't receive electronic transmission.

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Allowable Reasons for Not E-Prescribing



**G8446 E-Prescribing System Available, but not used for One or More Prescriptions Due to Patient/System Reasons**

- Provider does have access to a qualified system, but due to one of the following reasons in the code descriptor, cannot e-prescribe.
- Only the allowable reasons delineated in the code descriptor can be applied to G8446:
  - Controlled substance
  - State, federal law
  - Patient asks for hard copy
  - Pharmacy cannot receive eRx transmittal

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Medicare Incentive Payment:  
Positive and Negative rewards

Positive	Negative
2009-2010	2009-2011
2% incentive	no penalty
2011-2012	2012
1% incentive	1% penalty
2013	2013
0.5% incentive	1.5% penalty
2014	2014 and beyond
unclear	2% penalty

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ARRA Incentive Funding

- February 17, 2009 President Obama signed the American Recovery and Reinvestment ACT
  - 33 billion dedicated to Medicare and Medicaid incentives for physicians and hospitals who purchase and use Electronic Health Records (EHRs).
  - Bonus payments will only be made to “meaningful users” of qualified EHRs. To take maximum advantage of them, physicians will need to be ready by calendar year 2011 and hospitals will need to be ready by FY 2011 (beginning October 1, 2010).

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### “Qualified & Certified EHRs”

This distinction influenced the ARRA’s definition of a “qualified electronic health record” which is “an electronic record of health-related information on an individual that-

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity--

- (i) to provide clinical decision support;
- (ii) to support physician order entry;
- (iii) to capture and query information relevant to health care quality; and
- (iv) **to exchange electronic health information with, and integrate such information from other sources.”**

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### Medicare Physician Penalties

In 2015, reduction in Medicare reimbursements for physicians who are **not** meaningful EHR users  
 ( exceptions for significant hardship cases)

First Payment Year	Reduction in Medicare Fee Schedule for non-adoption
2011	\$0
2012	\$0
2013	\$0
2014	\$0
2015	-1%
2016	-2%
2017 and thereafter	-3%...

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### EHR Certification

- Certified EHR Technology: Qualified EHR that is also certified by meeting standards determined by type of record
- Certification Commission for Healthcare Information Technology, CCHIT, is one certification body. CCHIT certification requirements include EHR suitability, quality, interoperability and data portability, and security.




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## EHR Incentives

☐ To be eligible for incentive payments physicians must be “meaningful EHR users”

☐ Criteria:

- ☐ Demonstrate to HHS that they are using EHR in meaningful manner
- ☐ Participate in E-prescribing
- ☐ Technology provides electronic exchange of health information to improve quality of health care
- ☐ Submit information to HHS for quality measures

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## Medicare Physician EHR Incentives

	2011	2012	2013	2014	2015	2016	2017	TOTAL
Adopt 2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$0	<b>\$44,000</b>
Adopt 2012	-----	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	<b>\$44,000</b>
Adopt 2013	-----	-----	\$15,000	\$12,000	\$8,000	\$4,000	\$0	<b>\$39,000</b>
Adopt 2014	-----	-----	-----	\$12,000	\$8,000	\$4,000	\$0	<b>\$24,000</b>
Adopt 2015 +	-----	-----	-----	-----	\$0	\$0	\$0	<b>\$0</b>

<http://www.himss.org/ASP/index.asp>  
<http://www.ahima.org/>

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## Health Outcomes Policy Priority

- Improve quality, safety, efficiency, and reduce health disparities
- Engage Patients and Families
- Improve Care Coordination
- Improve Population and Public Health
- Ensure Adequate Privacy and Security Protection for Personal Health Information

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### Engage Patients and Families

2011 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions:*

- Provide patients with an electronic copy of their e-health information (including lab results, problem lists, medication lists, allergies, discharge summary, procedures) upon request
- Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists, allergies);
- Provide access to patient specific education resources
- Provide clinical summaries for patients for each encounter

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### Engage Patients and Families

**2011 Measures:**

- Percent of all patients with access to personal health information electronically
- Percent of all patients with access to patient specific educational resources
- Percent of encounters for which clinical summaries were provided

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### Improve Care Coordination

2011 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions:*

- Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
- Perform medication reconciliation at relevant encounters and each transition of care

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## Improve Care Coordination

### 2011 Measures:

- Report 30 day readmission rate
- Percent of encounters where med reconciliation was performed
- Implemented ability to exchange health information with external clinical entity (specifically lab, care summary and medication lists)
- Percent of transitions of care for which summary care record is shared (e.g. electronic paper, e-FAX)

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## Meaningful use?



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## Key Points

	<b>MEDICARE Physicians</b>
Incentive start	Calendar yr <b>2011</b>
Incentive end	Calendar yr <b>2016</b>
Incentive amount	Up to <b>\$44,000</b>
Reduction	Calendar yr <b>2015</b>

Sources: HIMSS <http://www.himss.org/ASP/index.asp>  
and AHIMA <http://www.ahima.org/>

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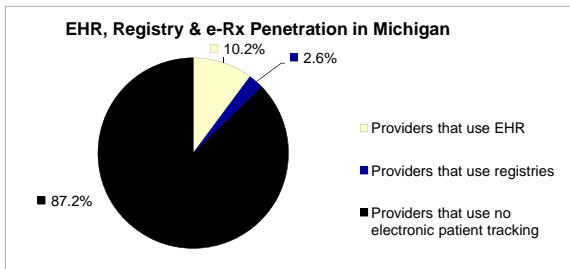
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### EHR Usage in Michigan




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### Regional Health Information Technology Extension Center (REC)

- Funding Opportunity Announcement released August 20
- Approximate number of awards: 70
- First round awards 14-20
- Three application cycles,
- Michigan submitted a state-wide application
- Over 200 Federally-supported practice networks; 14 HIE effort
- Approximately 18,000 PCPs; 7,000 priority PCPs
- Goal to reach 4,000-6,000 providers over the first 2 years

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### M-CEITA Charter Members

- Current organizations participating in Governance Committees\*
  - Altarum Institute (Prime Applicant & Program Management)
  - University Research Corridor: MSU, U of M, Wayne State
  - MPRO
  - MPCA
  - MPHI
  - Central Michigan University Research Corp (CMU-RC)
  - MOA
  - MSMS
  - MHA
  - Alliance for Health
  - HIMSS
  - MCHIT

\*in formation

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## REC's Scope of Services



**Direct Assistance Support**  
*Prioritized to priority primary care providers*

- Vendor selection and group purchasing
- Implementation and project management
- Practice and workflow redesign
- Functional interoperability and health information exchange
- Privacy and security best practices
- Progress towards meaningful use

**Core Support**  
*Available to all participating providers*

- **Education and outreach**
- Local workforce support
- Participation in peer-learning and knowledge transfer activities, facilitated by the national Health Information Technology Resource Center / National Learning Consortium

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## Next Steps



- First round due Nov 3 (Submitted Nov 2)
- Response expected early December
- Continue to work on Operational Model
- Begin Practice recruitment Jan 1



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## Questions???????



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