New developments in payment and public reporting of quality of care

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The long-term plan of Congress and the Center for Medicare and Medicaid Services (CMS) to tie health care reimbursement to the quality of health care services has been well-documented. CMS recently issued final rules that extend quality initiatives beyond inpatient hospitals to health care professionals and hospital outpatient departments. Authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS has now created incentive programs that affect the reimbursement of certain healthcare professionals and outpatient departments of hospitals.

As a result of changes authorized by MIPPA and implemented through the 2009 Physician Fee Schedule Final Rule (PFS Final Rule), physicians and other eligible professionals may earn a 2% bonus for the reporting of quality data specified by the Secretary of the Department of Health and Human Services (Secretary-HHS), and a separate 2% bonus for successfully transitioning to an electronic prescription system. The 2009 Outpatient Prospective Payment System Final Rule (OPPS Final Rule) implements a similar quality data reporting incentive that applies to hospital outpatient departments. The OPPS Final Rule authorizes a 2% payment reduction for outpatient departments that fail to meet certain outpatient reporting requirements during FY 2009. Finally, three recently published National Coverage Determinations from CMS will make certain "never events" non-covered services.

The onset of "pay for reporting" incentives can affect the pocketbook of professionals and entities which treat Medicare patients, but the incentives are also significant as a signal of CMS' continued commitment to tying payment to the quality of services provided. The long-term move toward a "pay for quality" system (called a "value based purchasing plan" by CMS) has been implemented

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incrementally, and CMS has made clear that the programs discussed below are intended as steps toward that goal. Many of the pay for reporting initiatives began as voluntary programs, designed to familiarize providers with the process of reporting and allow CMS to receive data on quality issues around the country. Under the new incentive programs, reporting remains voluntary, but there are now significant financial implications for reporting quality data. CMS makes clear that future programs may make reporting mandatory, and that payment may be tied to how well a provider performs on reported quality measures, rather than just on reporting.

Physician Quality Reporting Initiative

The Physician Quality Reporting Initiative (PQRI) began with the passage of the Tax Relief and Health Care Act of 2006 (TRHCA), which directed the Secretary-HHS to implement a system for certain healthcare professionals to report data on selected quality measures.[1] Reporting began in July 2007. (Previously, physician's could choose to participate in a Physician Voluntary Reporting Program.) Reports were not mandatory, but submission of the data in accordance with prescribed standards generated a bonus payment of 1.5% of the amount paid to the eligible professional for covered professional services during the reporting period. In July, 2008, MIPPA extended PQRI indefinitely and raised the bonus for years 2009 and 2010 to 2%.[2] The eligible professionals who can submit PQRI and receive the reporting bonus include certain midlevel practitioners, physicians, occupational therapists, qualified speech-language pathologists, and (starting in 2009) qualified audiologists.[3]

The importance of PQRI for physicians and other eligible professionals should not be underestimated. CMS has made clear that "pay for reporting" programs are a step toward a "pay for performance" or "pay for quality" reimbursement model (called a "value-based purchasing plan" by CMS). MIPPA directs the Secretary-HHS to submit to Congress a plan for the transition to pay for performance (P4P) with regard to physicians and other practitioners by May 1, 2010.[4] On November 26, 2008, CMS presented an issues paper which outlines the initial framework for such a plan, and conducted a day-long listening session to discuss the anticipated transition.[5]

The incremental movement toward P4P mirrors the approach taken with regard to hospitals. The Deficit Reduction Act of 2005 (DRA) established a 2% penalty for hospitals (referred to as subsection (d) hospitals)[6] that fail to report quality data, and directed the Secretary-HHS to develop a plan for implementing P4P for these hospitals for 2009.[7] That plan was submitted to Congress in November of 2007, but legislation has not yet been enacted in response. Subsection (d) hospitals are hospitals in the 50 States, Washington DC, and Puerto Rico, except for psychiatric hospitals, rehabilitation hospitals, hospitals whose inpatients are predominantly under 18 years old, and hospitals whose average inpatient length of stay exceeds 25 days. A current bill drafted by Senator Baucus (D-Montana) and Senator Grassley (R-Iowa) would implement P4P for subsection (d) hospitals starting in 2012, and phase in over a five year period until 2016.[8] Similar legislation, or an expansion of the current bill, which extends P4P to physicians and other healthcare professionals should be anticipated.

The ability to measure the quality of health care services accurately and efficiently is at the heart of CMS' vision of a value-based purchasing plan. When PQRI was first implemented in 2007, the data tracked 74 quality measures. The PFS Final Rule expands PQRI to include 153 quality measures for 2009, up from 119 measures in 2008, but less than the 175 measures originally proposed by CMS. MIPPA requires the Secretary-HHS to ensure that the affected professionals have an opportunity to provide input during the development or selection of quality measures, and CMS has invited comments on the measures both for PQRI and for the anticipated transition to P4P.

The 2009 quality measures include the 2008 PQRI measures plus certain measures endorsed by the National Quality Forum (NQF) and/or the AQA (formerly the Ambulatory Care Quality Alliance). The 2009 PQRI program also divides certain measures into seven measure groups, which are subsets of PQRI measures that have a particular clinical condition or focus in common. Details regarding the specific measures and measure groups included in PQRI for 2009 can be found at www.cms.hhs.gov/pqri. Technical specifications for reporting the measures and measure groups in the 2009 final listing can be found in the "Measures/Codes" tab of the PQRI section of CMS' website.

In addition to the quality measures which can be reported, the PFS Final Rule contains the criteria for submission which must be met to qualify for the incentive payment. In the past, reporting has encountered numerous hiccups. CMS data reveal that in 2007, just over half of those who participated successfully met the program and reporting requirements and received the reporting bonus.[9] In addition, many participants had difficulty accessing the confidential feedback reports CMS provided. These reports contained information as to whether the participant had met the criteria for satisfactory reporting, the amount of the incentive earned, and

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their measure performance rates. CMS has worked to streamline the process and educate eligible professionals about how to meet the requirements and is seeking ways to make accessing the feedback reports easier, but these difficulties emphasize the importance of becoming familiar with the system prior to the anticipated transition to a P4P reimbursement scheme.

Eligible professionals have several options available for reporting the data and qualifying for the 2% bonus. The options differ based on whether the professional chooses a claims-based or registry-based approach and whether the reporting pertains to individual measures or measure groups. The options available for claims-based submission of individual measures are the most restrictive. Registry-based reporting permits a physician to report through an authorized outside organization, such as certain trade associations. Registry-based submission using several different options is permitted and, for 2008 PQRI, there are 32 registries qualified to submit quality measures on behalf of eligible professionals. The PFS Final Rule sets forth the process that registries must go through in order to be qualified to submit data for eligible professionals for the 2009 PQRI program. There are six options available to a professional reporting on measure groups.

CMS does not, at this time, accept quality data through electronic health record (EHR) submission; however, it intends to test EHR vendors and their products during 2009 to determine if EHR reporting can be used in the future. If EHR vendors meet CMS' qualifications to participate in the PQRI testing process, their systems can submit quality measure data to CMS for PQRI on behalf of eligible professionals who use the systems.

In addition, MIPPA directs CMS to publicly report the names of eligible professionals who satisfactorily report quality data for 2009.[10] This marks a significant departure from the PQRI programs of 2007 and 2008, and is another of CMS' strategies for improving the quality of health care services. The names of successful reporters will be posted in 2010 on a "Physician and Other Health Care Professional Compare" website.[11] Although the individual quality data will not be posted, the PFS Final Rule responded to comments about publishing the data and stated that CMS' goal was to "eventually make performance information available."[12] The public posting of successful reporters should be regarded as the first step toward this process, and will lead to a website for physicians and other eligible professionals comparable to http://hospitalcompare.hhs.gov.

E-Prescribing incentive program

MIPPA and the PFS Final Rule also enact a separate incentive payment program for health care professionals who transmit a majority of their prescriptions electronically (e-prescribe). As with PQRI, the e-prescription incentive program is the next step in a long-term plan to improve the quality of care in the United States. Congress, in response to findings that e-prescription could prevent a significant number of medical errors, enacted a law in 2003 to help develop the infrastructure for its wider use.[13] The law made drug plans' acceptance of e-prescriptions a requirement for participation in the part D prescription drug benefit under Medicare, beginning in 2006, and CMS proclaimed the measure to be "one of the key action items in the government's plan to expedite the adoption of electronic medical records and build a national electronic health information infrastructure in the United States."[14] MIPPA takes the next step toward greater use of e-prescribing by creating significant financial incentives for physicians and other professionals who qualify as successful e-prescribers.

Under MIPPA, a successful e-prescriber is an eligible professional who, for a given reporting period, reports all the quality measures specified by the Secretary-HHS that relate to e-prescribing in at least 50% of the instances in which the measure could be reported by the professional. However, the PFS Final Rule included only one quality measure to be reported in the e-prescribing program, which relates to the capacity for and use of e-prescribing measures. In 2008, this quality measure was included in the PQRI, but was removed by MIPPA and made part of the separate e-prescribing incentive program for 2009. Although there is only one measure for the 2009 reporting period, CMS has said that it intends to consider the use of additional prescribing events as the basis of the incentive payment in future years.[15]

The reporting of e-prescription occurs through Medicare billing codes. To report one of the available codes for e-prescriptions, professionals must have a qualified e-prescribing system in place, and must have: (1) used it for all the prescriptions; (2) not generated any prescriptions during the encounter; or (3) been prevented from using the system by law, request of the patient, or the inability of the pharmacy system to receive e-prescriptions. CMS compares reported e-prescribing billing codes against the events reported to determine whether the professional qualifies as a successful e-prescriber.[16] Professionals have discretion in choosing the system they wish to use for e-prescribing; however, the system chosen must have the functionality established by the Medicare Part D e-prescribing standards.[17]

The financial incentives authorized by MIPPA take two forms. Starting in 2009, successful

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e-prescribers will receive an incentive payment. The bonus begins at 2% for years 2009 and 2010, but decreases in subsequent years and is eliminated entirely by 2014. The payment is separate from the incentive payments made under the PQRI, meaning eligible professionals could receive incentive payments of up to 4% in 2009. Second, beginning in 2012, a payment differential takes effect which penalizes prescribers by 1% if they do not qualify as successful e-prescribers. The amount of this differential increases in subsequent years to a maximum reduction of 2% by 2014. Thus, eligible professionals are offered incentives to transition to e-prescribing in the short-term, but these incentives steadily transition into penalties for failure to adopt and use an e-prescribing system in the future.

The definition of "eligible professionals" for the e-prescribing initiative is the same as for the PQRI, and includes physicians as well as physician assistants (PAs), nurse practitioners (NPs), clinical psychologists, registered dietitians, physical therapists, and qualified audiologists. However, eligibility is restricted to only those professionals who have prescribing authority, which may vary from state to state for certain types of practitioners, based on the scope of their practice. Moreover, to qualify for the incentive, the reported code for e-prescribing must constitute at least 10% of the professional's total Part B allowed charges. This limitation was enacted by Congress so that only those physicians or other eligible professionals who have the opportunity to prescribe a sufficient number of prescriptions can receive the incentive.

CMS will publish the names of successful electronic prescribers for the 2009 E-Prescribing Incentive Program on the Physician and Other Health Care Professional Compare Website (http://www.medicare.gov/Physician/Home.asp?bhcp=1). This means that both successful PQRI reporters and successful electronic prescribers now will be publicly reported by 2010.

Hospital outpatient quality data reporting program

The OPPS Final Rule, released November 18, 2008, implements another incentive program designed to encourage reporting quality data.[18] The rule expands upon existing hospital reporting requirements for outpatient services and implements the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), which reduces hospital outpatient payment rates by up to 2% if the hospital fails to meet the outpatient reporting requirements.

HOP QRDP was authorized by the Tax Relief and Healthcare Act (TRCHA) in 2006, to begin operating in 2009.[19] The 2008 OPPS Final Rule established seven quality measures relating to outpatient services, which were to be reported beginning in April, 2008.[20] Five of these measures apply to emergency departments and relate to acute myocardial infarction treatment, and two relate to outpatient surgery and the prevention of surgical infection. This year's OPPS Final Rule adds four new quality measures for FY 2009, focused on MRI of lumbar spine, mammography, abdominal CT, and thoracic CT. The adequate reporting of these measures will be used to determine if a hospital should be subject to the 2% reduction for FY 2010. The OPPS Final Rule also lists 18 different measures in nine measure sets from which additional quality measures could be selected for inclusion in HOP QDRP for FY 2011 and beyond.

The OPPS Final Rule explains the manner by which CMS will apply the 2% reduction in OPPS payment rates if a hospital fails to meet reporting requirements under HOP QDRP. The national unadjusted payment rates for many services paid under OPPS equal the product of the OPPS conversion factor and the scaled relative weight for the ambulatory payment classification (APC) to which the service is assigned. The OPPS conversion factor is updated annually, and CMS proposes to apply the 2% reduction to the conversion factor for purposes of implementing the HOP QDRP payment adjustment. This means that the payment reduction for failing to report under HOP QDRP will only apply to those OPPS services which are adjusted annually based on the conversion factor. For CY 2009, the reduction would be determined by multiplying the full national unadjusted payment rate for the applicable CPT code by 0.981.

Like the "Reporting Hospital Quality Data Annual Payment Update" program, CMS intends that reporting under HOP QDRP will be made public and has stated that the data will be posted to the CMS website by 2010. Hospitals will have an opportunity to review the data prior to publication. CMS is exploring whether Hospital Compare or other sites might be used for reporting of hospital outpatient quality data.

Health care-associated conditions and "never" events

Part of the value-based purchasing program already implemented by CMS has been a denial of payment for certain conditions considered to be preventable. In October 2008, CMS implemented its Hospital-Acquired Condition payment penalty to further that initiative.[21] Applicable to inpatient services only, the penalty denies any additional DRG payment for certain preventable complications that were not present on admission. Examples of hospital-acquired conditions

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include: retained foreign object after surgery, air embolism, blood incompatibility, stage III & IV pressure ulcers, falls and traumas such as electric shock and burns, and manifestations of poor glycemic control.

Two recent developments signal CMS' intent to expand this policy to professionals and to entities other than inpatient hospitals. First, in the OPPS Final Rule, CMS discussed in detail its intent to expand its Hospital-Acquired Conditions program to outpatient hospital and other settings. Coining the term "healthcare-associated conditions," CMS signaled its intent to extend the IPPS policy to hospital outpatient departments, ambulatory surgical centers (ASCs), skilled nursing facilities (SNFs), home health, physician practices, and other settings where preventable conditions can arise. Although no definitive policy changes were adopted in the OPPS Final Rule, CMS made clear that it views the ongoing problem of preventable healthcare-associated conditions in outpatient settings as a key strategy in its attempt to use Medicare payments to drive quality of care. This issue likely will be included in the joint IPPS/OPPS listening session that CMS intends to schedule this winter.

Second, CMS has taken its focus on "never" events in a different direction. Instead of including certain "never" events among the hospital-acquired conditions for which it currently denies payment if not present on admission, CMS has proposed three National Coverage Determinations (NCDs) eliminating payment for three serious medical errors: performing the wrong surgical or other invasive procedures on a patient; surgical or other invasive procedures performed on the wrong body part; and surgical or other invasive procedures performed on the wrong patient. The three NCDs were released on December 2, 2008, and CMS' goal is to issue them in final form by March, 2009. By using the NCD approach, the payment denial policy will extend beyond inpatient hospital care, affecting payment to physicians, hospital outpatient departments, and all other health care providers or suppliers which may be involved.

Conclusion

As the foregoing developments indicate, CMS continues to aggressively pursue strategies to tie payment to quality. It is expanding the scope of its pay-for-reporting initiatives to new settings and types of providers as a transition to pay for quality (value-based purchasing), and continues to expand the number of measures used to monitor quality. All healthcare entities and professionals are well advised to stay abreast of these new developments and to participate in them if they can, as payment tied to demonstrated quality of care is the Congressional goal in the not too distant future. ■

1 Tax Relief and Health Care Act of 2006, Pub. Law 109-432 (Dec. 20, 2006), adding subsection (k) to SSA § 1848 and 42 U.S.C. § 1395w-4.
2 The Medicare Improvements for Patients and Providers Act of 2008, Pub. Law 110-275 § 131(b) (July 15, 2008), amending SSA § 1848(k), (m) and 42 U.S.C. § 1395w-4(k), (m).
3 SSA § 1848(k)(3)(B); 42 U.S.C. § 1395ww-4(k)(3)(B).
4 Pub. Law 110-275 at § 131(d).
5 HHS, Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services (Nov. 26, 2008), available at http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf.
6 Subsection (d) refers to SSA § 1886(d); 42 U.S.C. § 1395ww(d). Subsection (d) hospitals are hospitals in the 50 States, D.C., and Puerto Rico, except for psychiatric hospitals, rehabilitation hospitals, hospitals whose inpatients are predominantly under 18 years old, and hospitals whose average inpatient length of stay exceeds 25 days.
7 Deficit Reduction Act of 2005, Pub. Law 109-171 § 5001(a), (b) (Feb. 8, 2006).
8 The drafted legislation is currently titled the Medicare Hospital Quality Improvement Act of 2008 (not yet numbered).
9 CMS, Physician Quality Reporting Initiative: 2007 Reporting Experience (Dec. 3, 2008) available at http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf.
10 Pub. Law. 110-275 § 131(b)(3), adding SSA § 1848(m)(5)(G); 42 U.S.C. § 1395w-4(m)(5)(G).
11 2009 Physician Fee Schedule Final Rule, 73 Fed. Reg. 69725, 69846-47 (Nov. 19, 2008).
12 Id. at 69845.
13 Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. Law 108-173 (Dec. 8, 2003), adding SSA § 1860D-4(e), 42 U.S.C. § 1395w-104(e).
14 CMS, Overview of E-Prescribing program, http://www.cms.hhs.gov/eprescribing/.
15 2009 Physician Fee Schedule Final Rule, 73 Fed. Reg. 69725, 69848 (Nov. 19, 2008).
16 For specific codes, see CMS, Medicare's Practical Guide to the E-prescribing Incentive Program (Nov. 2008), available at http://www.cms.hhs.gov/partnerships/downloads/11399.pdf.
17 Information about the qualified e-prescribing systems can be found at CMS, 2009 Electronic Prescribing Incentive Program – Adoption/Use of Medication Electronic Prescribing Measures, (Nov. 7, 2008) available at http://www.cms.hhs.gov/PQRI/Downloads/E-PrescribingMeasureSpecifications.pdf.
18 73 Fed. Reg. 68502, 68758 (Nov. 18, 2008)
19 Pub. Law. 109-432 Part B § 109 (Dec. 20, 2006), adding SSA § 1833(t)(17), 42 U.S.C. § 1395(l)(t)(17).
20 72 Fed. Reg. 66580, 66860 (Nov. 27, 2007).
21 Inpatient Prospective Payment System FY 2009, 73 Fed. Reg. 48434, 48471 (Aug. 19, 2008).