



Advancing the National Strategy for Quality Improvement in Health Care

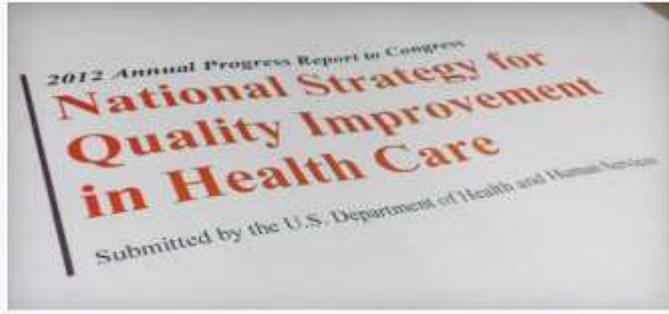


HONSAC

April 4, 2013

***CAPT Tom Duran, RPh
Pacific Area Representative for
Hawaii and the Territories***

National Quality Strategy (NQS) promotes better health, healthcare, and lower cost



The **Affordable Care Act (ACA)** requires the Secretary of the Department of Health and Human Services (HHS) to establish a ***national*** strategy that will improve:

The delivery of health care services

Patient health outcomes

Population health

The strategy is to concurrently pursue three aims

Better Care

Improve overall quality by making health care more patient-centered, reliable, accessible and safe.

Healthy People / Healthy Communities

Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.

Affordable Care

Reduce the cost of quality health care for individuals, families, employers and government.

Collaboration

- Collaborative effort across all health care sectors
- Partnership with National Quality Forum (NQF)
 - Independent nonprofit organization
 - Refines and endorses standards and measures of health care quality
 - National consensus based approach
- Interagency Working Group (Federal)

Measuring Quality

- Build a National consensus on how to measure quality
- Best and most relevant measures
- Avoid creating undue burden of collection
- Increase focus on clinical outcomes and patient-reported experience measures

Patient Experience Examples

- Hospital Value-Based Purchasing Program
 - 30-day condition-specific mortality measures
 - Hospital Consumer Assessment of Healthcare Providers and Systems
 - Linking clinical outcomes and **patient**-reported experience of care to provider payments
- End-Stage Renal Disease Quality Incentives
 - In-center dialysis **patient** experience survey
 - High quality, **patient**-centered care

NQS Priorities

- Making care safer by reducing harm caused in the delivery of care
- Ensuring each person and family are engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality

NQS Priorities

- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and government by developing and spreading new health care delivery models

Additional Information

- <http://www.healthcare.gov/news/reports/quality03212011a.html>
- <http://www.ahrq.gov/legacy/qual/measurix.htm#quality>

CMS Programs



Program Enrollment

- CMS is one of the largest purchasers of health care in the world
 - Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans
 - Medicare enrollment has increased from 19 million beneficiaries in 1966 to now over 50 million beneficiaries
- Over one billion Medicare claims are processed annually

History of DMEPOS Competitive Bidding

- Program builds on successful demonstrations
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the development and implementation of the program
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made limited changes
- The Affordable Care Act expanded the program

How the Program Works

- DMEPOS suppliers submit bids
 - Suppliers must submit a bid to be awarded a contract
- Medicare uses bids to determine payments
- Contracts will be awarded to sell/rent DMEPOS
- “Contract suppliers” will be those who
 - Offer the most competitive price
 - Meet eligibility, quality, and financial standards
 - Are accredited by an independent organization

How the Program Works

- Only contract suppliers will be able to
 - Provide competitively bid DMEPOS items
 - File claims with Medicare for payment of competitively bid items and services
- Contract supplier charge cannot exceed
 - Single payment amount based on bids received for an item
 - Medicare fee schedule allowed amount

Round 1

- January 1, 2011 in 9 areas
- First year savings = \$202.1 million
- Round 1 contracts being recompeted in the same areas

Round 2

- Competitive Bidding Program will expand
 - Round 2
 - 91 Metropolitan Statistical Areas (MSAs)
 - Target effective date July 1, 2013
 - National Mail-Order Program

National Mail Order Program for Diabetic Testing Supplies

- Targeted to go into effect at the same time as Round 2
- Includes all parts of the United States:
 - The 50 States
 - The District of Columbia
 - Puerto Rico
 - The US Virgin Islands
 - Guam
 - American Samoa

Who will be Affected?

- Beneficiaries who have Original Medicare and
 - Permanently reside in a ZIP Code in a CBA
 - Obtain competitive bid items while visiting a CBA
- To find out if a ZIP Code is in a Competitive Bidding Area (CBA)
 - Call 1-800-MEDICARE (1-800-633-4227)
 - TTY users call 1-877-486-2048
- Medicare Advantage enrollees can use suppliers designated by their plan

Region IX: Round 2 MSAs

Includes 91 Metropolitan Statistical Areas

Guam: None

Hawaii

- Honolulu, HI

Samoa: None

Using Contract Suppliers

- Must almost always use contract supplier if
 - Items and services are included in Competitive Bidding Program where a beneficiary lives in a CBA
 - Traveling to or visiting a CBA
- Doctors, treating practitioners, and hospitals can supply certain items (ex: walkers or folding manual wheelchairs)
- Nursing Facility can only supply directly if it becomes a contract supplier

Non-contract Supplier

- If in CBA, a non-contract supplier may not furnish bid items
- If non-contract supplier used, supplier must issue Advance Beneficiary Notice (ABN)
 - Says Medicare will not pay
 - By signing, beneficiary agrees to pay entire amount
 - If no ABN signed, beneficiary not responsible for payment

Points to Remember

- Program does NOT affect which physicians or hospitals beneficiaries use
- May need to change DMEPOS supplier for Medicare to pay
- May be able to stay with current supplier if renting from supplier who elects to be “grandfathered”
- If in Medicare Advantage plan, beneficiary should check with the plan

DMEPOS Questions

- Supplier questions
 - Competitive Bidding Implementation Contractor (CBIC)
 - 877-577-5331 (toll free)
 - www.dmecompetitivebid.com
- Visit www.medicare.gov/supplier
 - DMEPOS Supplier Locator Tool
- Visit www.medicare.gov website
 - Consumer information

What is the EHR Incentive Program?

- The American Recovery and Reinvestment Act (ARRA) of 2009 authorized CMS to provide incentive payments to eligible professionals, hospitals, and critical access hospitals to adopt and use certified EHR technology in ways that positively affect patient care
- The program is NOT a reimbursement program for purchasing or replacing an EHR

Medicare EHR Incentive Program

- Eligible participants can receive up to \$44,000 over five consecutive years
- Program runs from 2011 through 2016
- Program is managed by CMS
- Payment adjustments begin in 2015 for providers who are eligible but elect not to participate
- Must demonstrate meaningful use (MU) every year to receive incentive payments

What is Meaningful Use?

- Affectively using EHRs, by meeting specific objectives and clinical quality measures, in ways that positively affect the care of patients
- Example:
 - Objective – Generate and transmit permissible prescriptions electronically (eRx)
 - Measure – More than 40% of all permissible prescriptions written are transmitted via eRx

Eligible Professionals

- Incentive payments are based on individual practitioners and each may qualify for an incentive payment
- Each eligible professional is only eligible for one incentive payment per year, regardless of how many practices or locations involved
- Hospital based (90% inpatient or ER services) eligible professionals are not eligible for incentive payments

EHR Questions

- Electronic Health Record Information Center
 - 888-734-6433 (toll free)
- Visit <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>
- Certified EHRs
 - <http://oncchpl.force.com/ehrcert>
- Visit www.cms.gov website

ACA Strengthens Medicare

- Many free preventive services
- For 2013 the law provides people with Medicare in the donut hole with greater savings - discounts rise to 53 percent of the cost of brand name drugs and 21 percent of the cost of generic drugs
- The donut hole will be closed in 2020
- Strong anti-fraud measures, including tougher penalties for criminals
- Incentives to improve care coordination
- 150,000 primary care providers received \$560 million in bonus payments in 2011, and these increases continue through 2015

Two+ Years Later: The Benefits of the ACA

- Free preventive services include mammograms and colonoscopies or a free annual wellness visit with their doctor.
- In 2011, an estimated 32.5 million people with original Medicare or Medicare Advantage received one or more free preventive benefits.
- In the first 10 months of 2012 alone, about 23.4 million people with original Medicare received one or more preventive services at no cost to them, with 2.5 million having received an annual wellness visit.

Two+ Years Later: The Benefits of the ACA

Making prescription drugs affordable for seniors

- Savings on prescription drugs made possible by the ACA reached \$5.1 billion in October 2012.
- More than 5.8 million people with Medicare have benefited from the assistance with the Medicare prescription drug coverage gap known as the donut hole.
- In the first 10 months of 2012 alone, almost 2.8 million individuals have saved an average of \$677 on prescription drugs.

Affordable Insurance Exchanges

- Supporting Hawaii's Efforts
 - Hawaii has received \$77,255,636 in grants for research, planning, IT development, and Exchange Implementation
 - \$1,000,000 in Planning Grants
 - \$76,255,636 in Exchange Establishment Grants

Physician Quality Reporting System (PQRS) and Value Modifier

- PQRS incentive: ends in 2014
- PQRS payment adjustment: starts in 2013; overlaps with the incentive for 2 years
- Value Modifier: first reporting year is 2013; affects payment in 2015
 - Must include all providers by payment year 2017 (measurement year 2015)

What is the Value-Based Modifier?

- The Affordable Care Act requires that Medicare phase in a value-based payment modifier (VM) that would apply to Medicare Fee for Service Payments starting in 2015; phase-in complete by 2017
- The VM assesses both quality of care furnished and the cost of that care
- The Value-based Payment Modifier aligns with PQRS
- The proposals
 - Encourage physician measurement and alignment with PQRS
 - Offer choice of quality measures and reporting mechanisms
 - Focus payments on outliers in the first year
 - Provide actionable information
- Challenging and complex program
- Must be budget neutral

Accountable Care Organizations

- **259 ACOs**
 - 221 Medicare Shared Savings Program ACOs
 - 35 also participating in the Advance Payment Model
 - 32 Pioneer ACOs
 - 6 Physician Group Practices
- **Over 4 million beneficiaries** receiving care from ACO providers

Advance Payment ACO Model

GOAL: Providing additional support to physician-based & rural ACOs participating in the Medical Shared Savings Program.

- Will test whether pre-paying a portion of future shared savings will increase participation of physician-owned and rural ACO's.
- Payments will be recouped through shared savings earned by ACO.
- Open only to ACOs participating in Shared Savings Program
- Three start dates:
 - **April 1, 2012** start date: **5** ACOs selected
 - **July 1, 2102** start date: **15** ACOs selected
 - **January 1, 2013** start date: **15** ACOs selected

Additional Information

- http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFORepor/Downloads/2012_CMS_Financial_Report.pdf
- <http://www.healthcare.gov/law/information-for-you/hi.html>
- <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

Contact Information



CAPT Tom Duran, RPh

Pacific Area Representative

808-541-2732

tom.duran@cms.hhs.gov