Quality Measurement: Past, Present and Future

Timothy A. Pflederer, MD
Chair, ASDIN Public Policy Committee
Board member, RPA

No other disclosures

Thanks to Adam Weinstein who provided slides related to physician payment incentive programs

Outline

• Impact of quality programs and measures
• How quality measures are developed
• Opportunities moving forward

Percentage of Providers e-prescribing

Physician focused quality incentive programs

• Meaningful use (MU)
• Physician quality reporting systems (PQRS)
• Value based payment modifier (VBPM)

Common characteristics:
• Start simple then become increasingly difficult
• Begin with incentive then transition to penalty
Meaningful use Incentive Payments To Date thru 2013+

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$12,000</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$-1%</td>
</tr>
<tr>
<td>Total</td>
<td>$44,000</td>
<td>$44,000</td>
<td>$39,000</td>
<td>$24,000</td>
<td></td>
</tr>
</tbody>
</table>

* Penalties may increase to -5% in 2018

Meaningful use: Stage 2 Core Objectives

- Ordering prescriptions
- Ordering lab tests
- Sending prescriptions to the pharmacy electronically
- Recording patient history and demographic information
- Providing reminders for guideline-based interventions
- Providing warnings of drug interactions or contraindications
- Reporting to immunization registries electronically

Meaningful use

- If you do not attest (or meet hardship exemption to opt out) you will be subject to 1% reduction in payment for all Medicare Part B billing in 2015 and 2% in 2016
- The penalty increases each year to 5% by 2018-19

PQRS

- Physician quality reporting system
- Formerly PQRI – physician quality reporting initiative
- Aimed at individual physicians
- Requires reporting of CMS “endorsed” quality measures
- Measures grouped by domain
- Patient safety, Effective clinical care, Communication and care coordination, etc
- Allows reporting through a number of options
- Qualified clinical data registry, EHR, Claims based, etc

The Evolution of PQRS
Endorsed measures

- RPA has stewardship of a number of these measures
- Related to CKD and ESRD patient care
- None applicable to interventional nephrology
- Within all 287 endorsed PQRS measures very few could even be utilized by IN to report PQRS
  - Measure # 76 – Maximum sterile barrier used during catheter insertion
  - Measure # 145 – X-ray exposure time reported for fluoroscopy procedures
  - Measure # 357 – Surgical site infection
  - Others: smoking cessation, medication reconciliation, vaccination

PQRS

- Must report on at least 50% of all Medicare FFS patients
- In 2014 there was opportunity for 0.5% increase for MOC participation
- 2% penalty for not reporting
  - Reduction in payment for all Medicare Part B claims
- Report now to avoid the penalty in 2 years
  - 2015 – already being penalized if you did not participate in 2013
  - 2016 – report 3 measures across 1 domain from 1 quarter in 2014
    - Deadline for submitting data is February 26, 2015
  - And it gets harder ...
    - 2017 – report 9 measures across 3 domains from entire year (?) in 2015

You are directly impacted today

- The upside is gone – its all penalty from here
  - Program penalties are additive
- You have no quality measures that are specific to what you do
- The potential negative impact is growing if you are strictly FFS billing
  - Negative VBPM will not be applied to those participating in alternate value based payment models

The outcome:
CMS believes that this will drive physicians out of FFS and into value based payment models

Your response

- Retire early
- Play the game
- Prepare for value based payment
- Develop useful quality measures

Utility of measure

- Endorsed Measures
- Evolving Measures
- Undeveloped Measures
What kills a measure?

- Not broadly applicable or accepted
- Not clinically relevant
- Not specific
- Too hard to collect
- Unable to meet specific criteria for becoming a formal national quality measure
  - National guidelines clearinghouse (NGC)

Utility of measure

- Endorsed Measures
- Evolving Measures
- Undeveloped Measures
- Uncertain Utility
- Internal QI
- Quality Assurance and Improvement
- Public reporting
- You Are Here
Its time to get moving ...

- Develop quality measures specific to dialysis vascular access and interventional nephrology
- Partner with existing data registry
  - RPA
  - PEER
  - USRDS
  - Another

Why the RPA Registry?

- As a CMS-approved Qualified Clinical Data Registry (QCDR), the RPA Registry collects data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients and is not limited to PQRS measures.
- The RPA Registry is currently the only nephrology-specific QCDR, enabling the RPA to set the standards for quality renal care in the US allowing the specialty to develop and test measures for the discipline
- RPA has been the lead nephrology organization responsible for developing and testing physician performance measures (currently over 30 measures specific to nephrology)
- ASDIN and RPA have an existing close collaborative relationship

Summary

- Quality measures are being used to determine physician payment and penalty
- There is a critical need for quality measures specific to dialysis access and interventional nephrology
- ASDIN should lead in developing measures
- Partnering with RPA leverages our existing relationship, RPA expertise in measure development, and the technologic platform to accomplish this goal