Quality Improvement, Health Information Technology, and the Shift to Pay for Value

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Health care reform encompasses the need to design quality improvement initiatives that involve health information technology adoption and the overall gradual shift to pay-for-value models. For years, MetaStar has provided support for such initiatives in physician offices. Currently much of this work is performed through MetaStar's partnership in the Lake Superior Quality Innovation Network, which contracts with the Centers for Medicare & Medicaid Services (CMS) to provide quality improvement assistance for those who provide care to Medicare beneficiaries. MetaStar also has supported such initiatives through its work with the Office of the National Coordinator for Health Information Technology, as well as in its privately funded work. A few areas of focus for physicians are the use of data to identify high-risk patients, care coordination, and patient-centered care.

For years, clinics have been working towards adoption of certified electronic health records (EHRs) and the 3 stages of Meaningful Use: data capture and sharing (Stage 1), advanced clinical processes (Stage 2), and improved outcomes (Stage 3), with each stage building upon the previous one. Clinics started the journey by capturing data in the EHR (generating patient lists by specific conditions) and then continued with improvements in health information exchange and care coordination. Recently, CMS published the proposed Stage 3 rule: to improve clinical outcomes, we need to utilize the data captured in EHRs to identify high-risk patients, and hence better to manage and mitigate disease.

Have you ever referred a patient to a specialist, but didn't receive complete information back as to the outcome of that visit? Or have you received a patient referred for specialized treatment, but weren't sure what tests already had been ordered by the primary care physician? Health care information systems frequently do not talk to one another, which can create confusion. Care coordination is essential not only from the patient perspective, but also from the payer and provider side of health care. When professionals can communicate through the patient's health record, they potentially can reduce errors and increase patient-provider satisfaction.

Similarly to the growing use of technology, pay-for-value models have evolved over the past few years. The stage is being set for consumers to "shop online" for their health care. For example, consumers can research which hospital had the most expensive heart transplant procedure, which home health agency had the highest rate of patients who experienced ambulation improvement and, which nursing home had the highest incidence rate of developing pressure ulcers. Access to such information will be an inevitable factor as health care reform and quality improvement initiatives move forward.

CMS initiates this process by defining a set of standardized measures for quality reporting. Physicians and other health care professionals may be familiar with a few of these programs such as the Physician Quality Reporting System (PQRS), Hospital Inpatient Quality Reporting (IQR), or Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS). These are programs where measures have been defined, processes have been rolled out, and reporting has become fluid within clinical workflows.

After measures have been defined, the cycle moves into its next phase: pay for reporting. Penalties are imposed when organizations do not submit those previously defined CMS measures. Conversely, when those measures are submitted, CMS provides full reimbursement.

The next part of the process is pay for performance. The measures that CMS previously collected and providers reported on are compared (hospital vs hospital, nursing home vs nursing home). These data are then translated into public reporting. This feature of public reporting enables patients to compare and contrast different providers where circumstances permit, and to determine where they want to receive services based upon previous clinical outcomes. Providers with the highest performance of those measures can receive bonus payments in addition to their standard reimbursements.

A Summary of Approaches and Programs

PQRS (Physician Quality Reporting System)

- Created in 2006 by CMS as a pay-for-reporting program.
- Uses incentive payments to encourage eligible professionals to report on specific quality measures.
- Eligible professionals in this program are those based on or paid by the Medicare Physician Fee Schedule, including physicians, practitioners, and therapists.
- If providers have not submitted their quality data to CMS, they will see a 1.5% cut this year.

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Doctor Gold is senior vice president and chief medical officer for MetaStar. Caitlin McLeish, Health Information Technology Specialist at MetaStar, also contributed to this article. This material was prepared by the Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy. 11SOW-MI-A1-15-05 0450615

Meaningful Use of EHRs

- Established in 2009 as part of the American Recovery and Reinvestment Act.
- Part of the Medicare and Medicaid EHR Incentive Programs.
- Eligible professionals and hospitals meaningfully use certified EHRs to improve patient care by meeting thresholds for a number of objectives.
- The Stage 3 proposed rule was released earlier this year.

Value-Based Payment Modifier

- The Affordable Care Act mandated this payment structure in 2015 based on performance in 2013.
- Provides payments to physicians under the Medicare Physician Fee Schedule based upon the quality of care provided compared to the cost of care provided.
- The modifier currently is applied to groups of 100 or more eligible professionals.

Hospital-Acquired Condition (HAC) Reduction Program

- Signed in 2006 as part of the Deficit Reduction Act.
- In 2009, the HAC payment adjustment was rolled out driving improvements in patient safety by using payment adjustments based on DRGs (Diagnostic Related Groups) that use CCs (complicated conditions) when present as secondary diagnoses.

MetaStar will continue to work with physicians and hospitals throughout Wisconsin to improve their ability to participate in these approaches, with the ultimate goal of improved patient care.

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