

Mountain-Pacific Quality Health

QIO/CMS Update

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and

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Our Mission

To improve the quality of health care through review, consultation, education, and training.



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Who IS Mountain-Pacific?

- Four separate but affiliated corporations
- Combined Board of Directors
- One CEO
- Some Shared Staff
- In QIO-world we are referred to as “instate” organizations – important at renewal time.

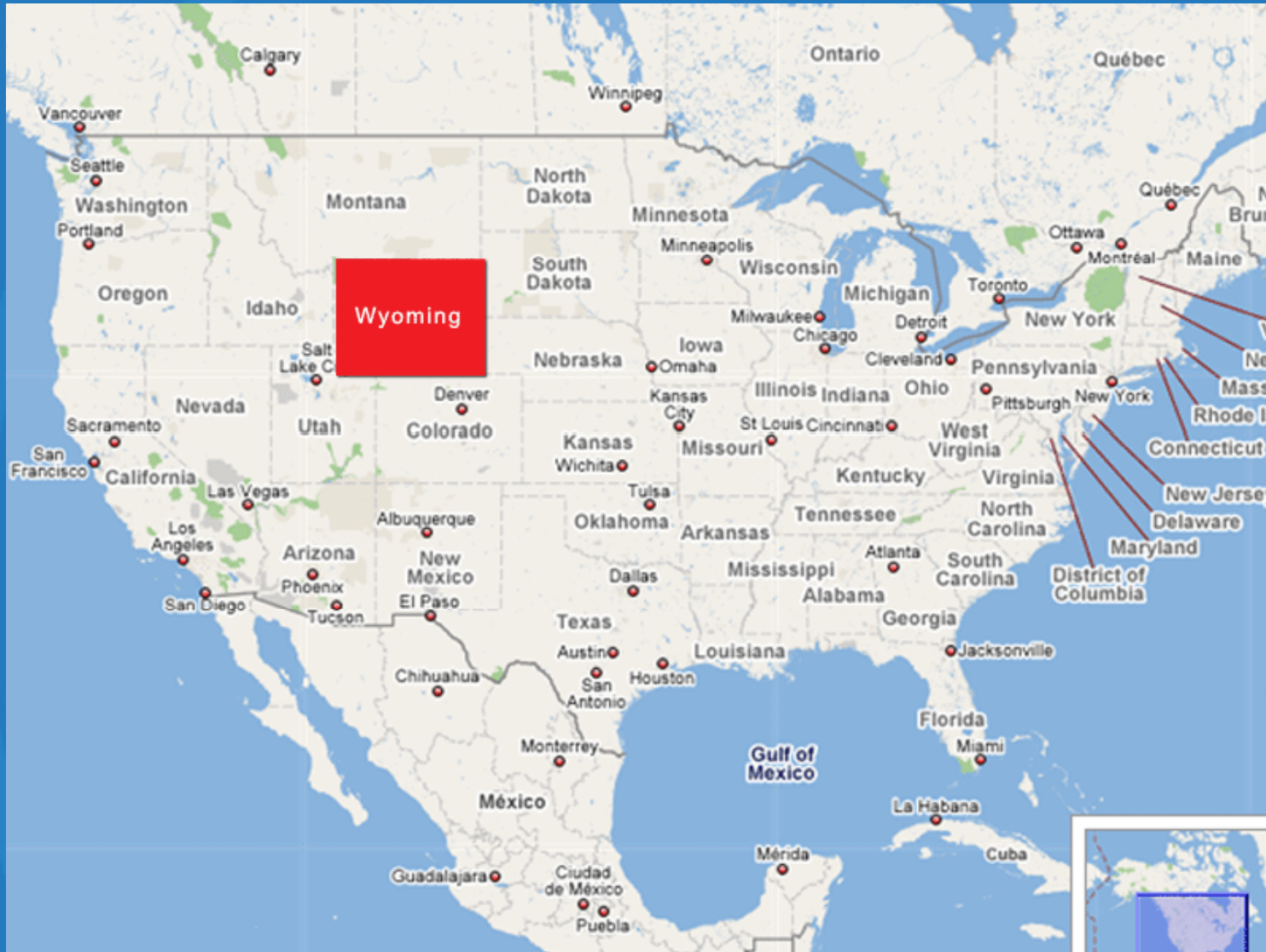


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Four Fabulous States to Work In



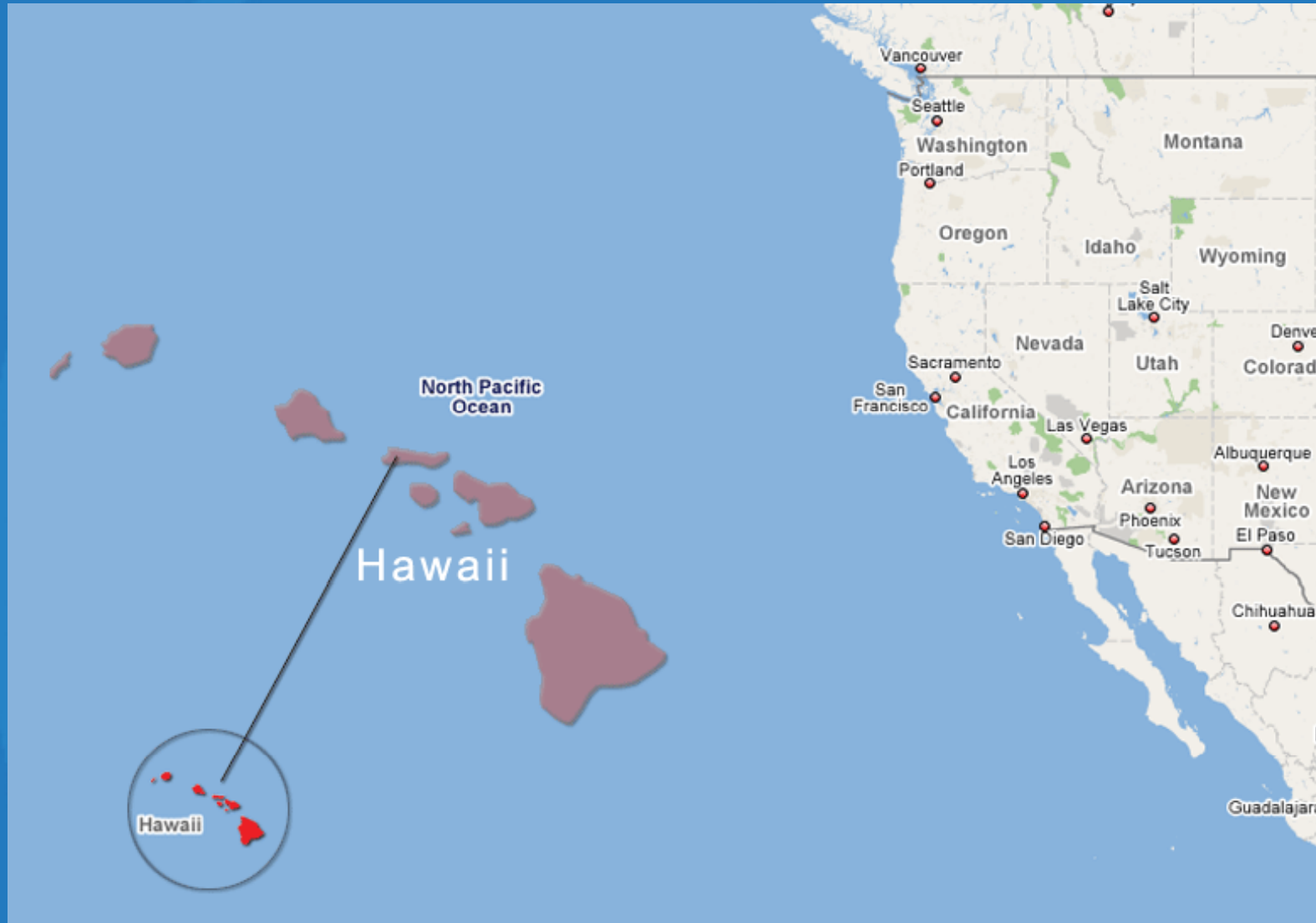
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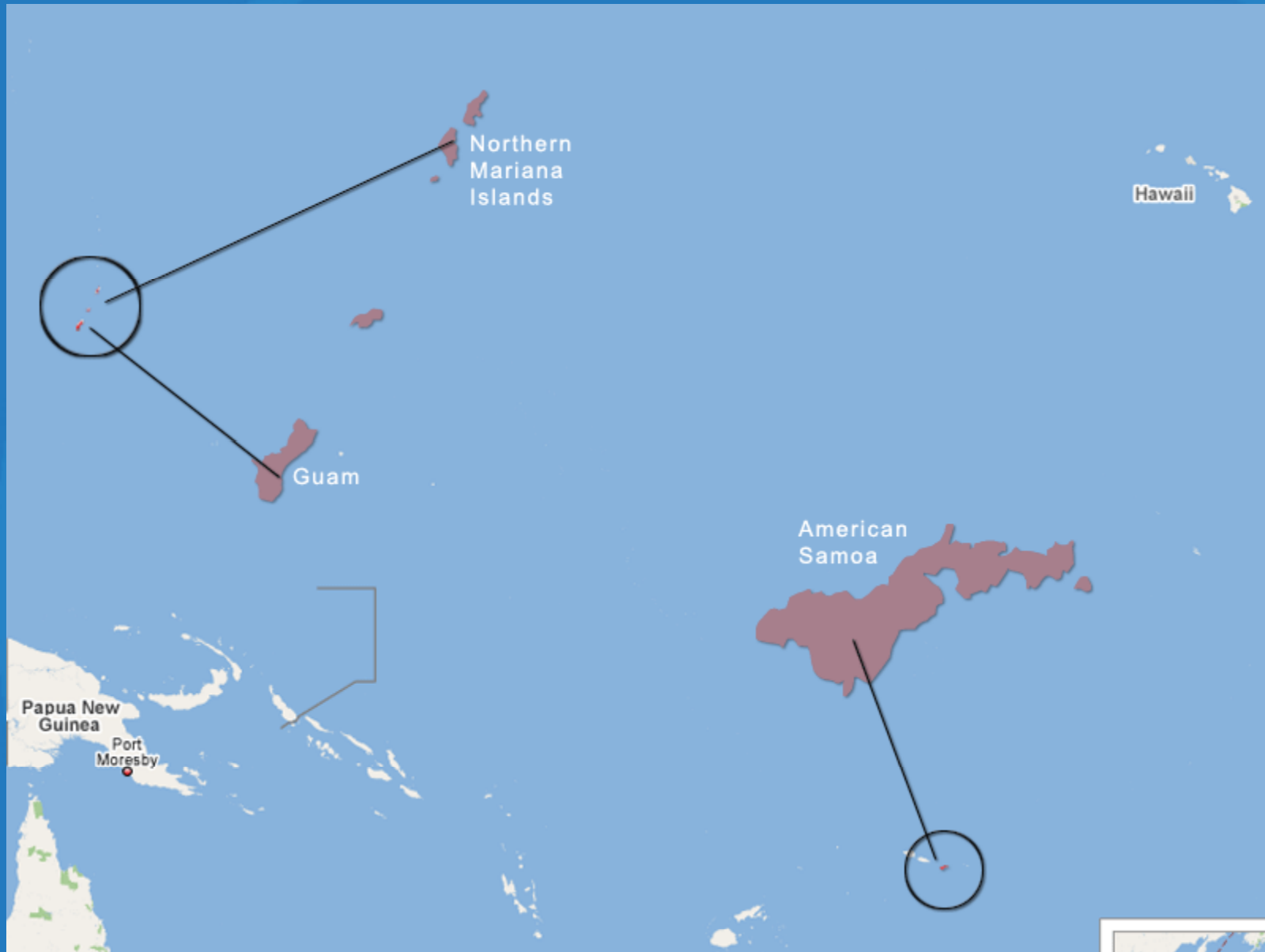
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Our Statistics

- 36 years old – incorporated in 1973
- 85 employees
- 10 million per year budget
- Four offices
 - Helena, Montana – corporate
 - Everywhere, Wyoming (actually 6 home based workers)
 - Anchorage, AK
 - Honolulu, HI



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More details

- 20% of all physicians in each state belong as members to Mountain-Pacific
- Board of Directors elected by the membership
 - 10 physicians (3 from Hawaii)
 - 10 other professionals (4 from Hawaii)
 - Statistician, executives, HIT professional, health information manager, adult educator, consumers, lawyer.

Funding

- Only source of funding is through contracts.
 - Four QIO contracts – 65%
 - 10 Medicaid contracts – 34%
 - 20 contracts with private facilities, insurance companies. - 1%
 - 501C6 organization



Centers for Medicare & Medicaid Services (CMS) – QIO contracts:

- Improve quality of care for beneficiaries
- Protect integrity of the Medicare trust fund
- Protect beneficiaries by expeditiously addressing individual complaints

9th Statement of Work (9th SOW)

Three Themes...

- Beneficiary Protection
- Patient Safety
- Prevention



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Beneficiary Protection Theme

- Utilization review
- Beneficiary complaints – promoting mediation (ADRs)
- Hospital-based notice appeals, fee-for-service expedited appeals and Medicare Advantage fast-track appeals
- EMTALA
- Assistants at Cataracts



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Beneficiary Protection

- Sanction activities
- Physician acknowledgement monitoring
- Collaborate with key stakeholders
- Transparency through reporting
- Assisting hospitals with quality data reporting
- Maintenance of a beneficiary helpline



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Medicare Administrative Contractor (MAC) Referrals

- Types of MAC referrals:
- Readmissions occurring less than 31 days from date of discharge from same or another acute, general, short-term hospital
 - Perform case review on both stays
 - Analyze cases to determine potential premature discharge from 1st admission

MAC Referrals (cont'd)

- MAC Coverage Referral for services, items or procedures that may not be covered or are excluded from coverage
 - Review for medical necessity
 - Perform quality of care review if indicated



Recovery Audit Contractor (RAC) Referrals

- RACs will refer case with quality of care concerns to the QIO
- Mountain-Pacific will request the medical record and refer potential concerns to a physician reviewer



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Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)



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This includes:

- Data submission reports
- Tools that are available to hospitals
- Clinical process measures
- Identification of data successfully accepted into the warehouse
- Analyzing completeness of hospital submitted data
- Provide technical assistance for CART
- Hold statewide trainings on CMS-identified and approved topics when new versions are released
- Manage the interface between hospitals and QualityNet Exchange
- Work with hospitals to improve accuracy, timeliness and completeness of data submitted to the QIO clinical warehouse



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Beneficiary Helpline

- Provide callers with information concerning
 - Medicare beneficiary rights and responsibilities
 - Beneficiary protections
 - QIO programs and or initiatives.
- The Helpline is staffed seven days a week
8:30 a.m. to 4:30 p.m.
- 1-800-497-8232



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Hawaii Helpline Call Volume

- Average of 18 Beneficiary calls a month
- Average minutes per call – 38 minutes
- Types of calls:
 - Billing questions
 - Appeals
 - Complaints



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Patient Safety Theme

Provide technical assistance and support to a limited number of hospitals chosen by CMS...

- MRSA
- Pressure ulcers
- SCIP



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Focus on Six Components

- **Improving** inpatient surgical safety and heart failure
- **Reducing** rates of pressure ulcers in nursing homes and hospitals
- **Reducing** rates and use of physical restraints
- **Improving** drug safety
- **Reducing** rates of health care-associated Methicillin-resistant *Staphylococcus aureus* (MRSA)
- **Activities** aimed at nursing homes in need of assistance with quality improvement efforts



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Hospital Compare

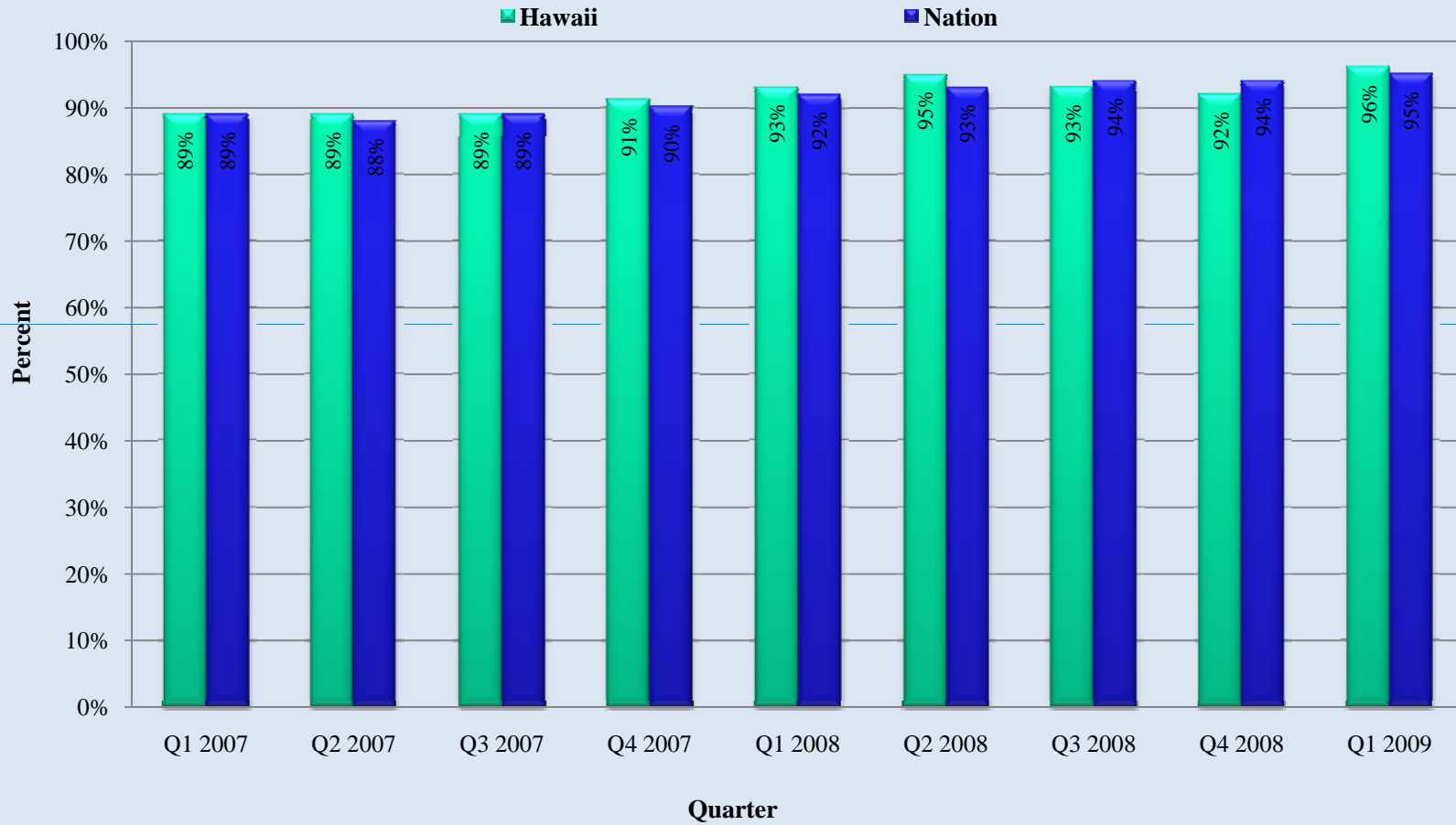
Shows how often hospitals:

- Provide recommended care for heart failure, pneumonia, heart attacks, surgery
- 30-day mortality rate for pneumonia, heart failure, and heart attack
- Medicare volume and payment information for certain DRGs
- Patient satisfaction
- www.hospitalcompare.hhs.gov

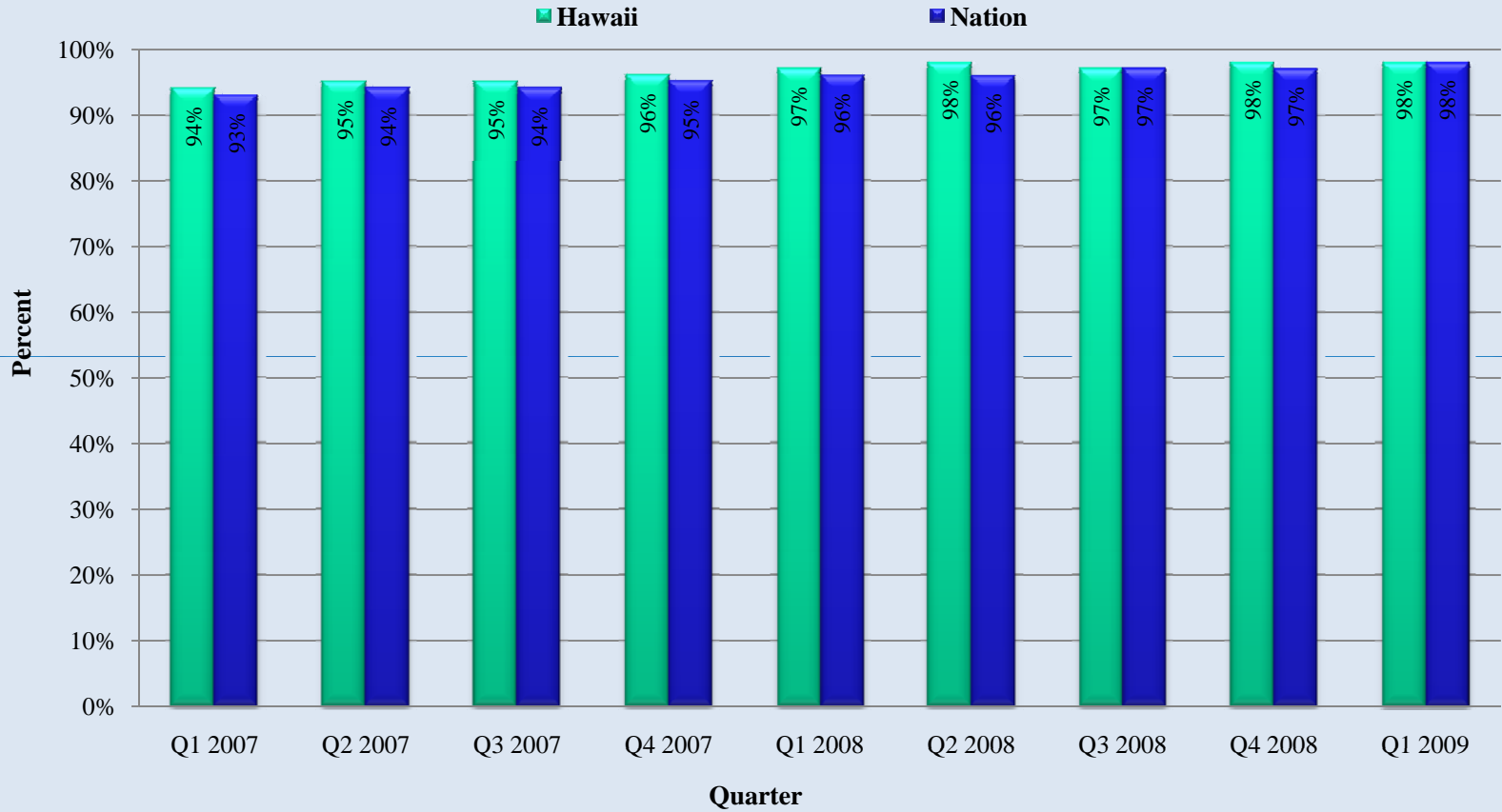


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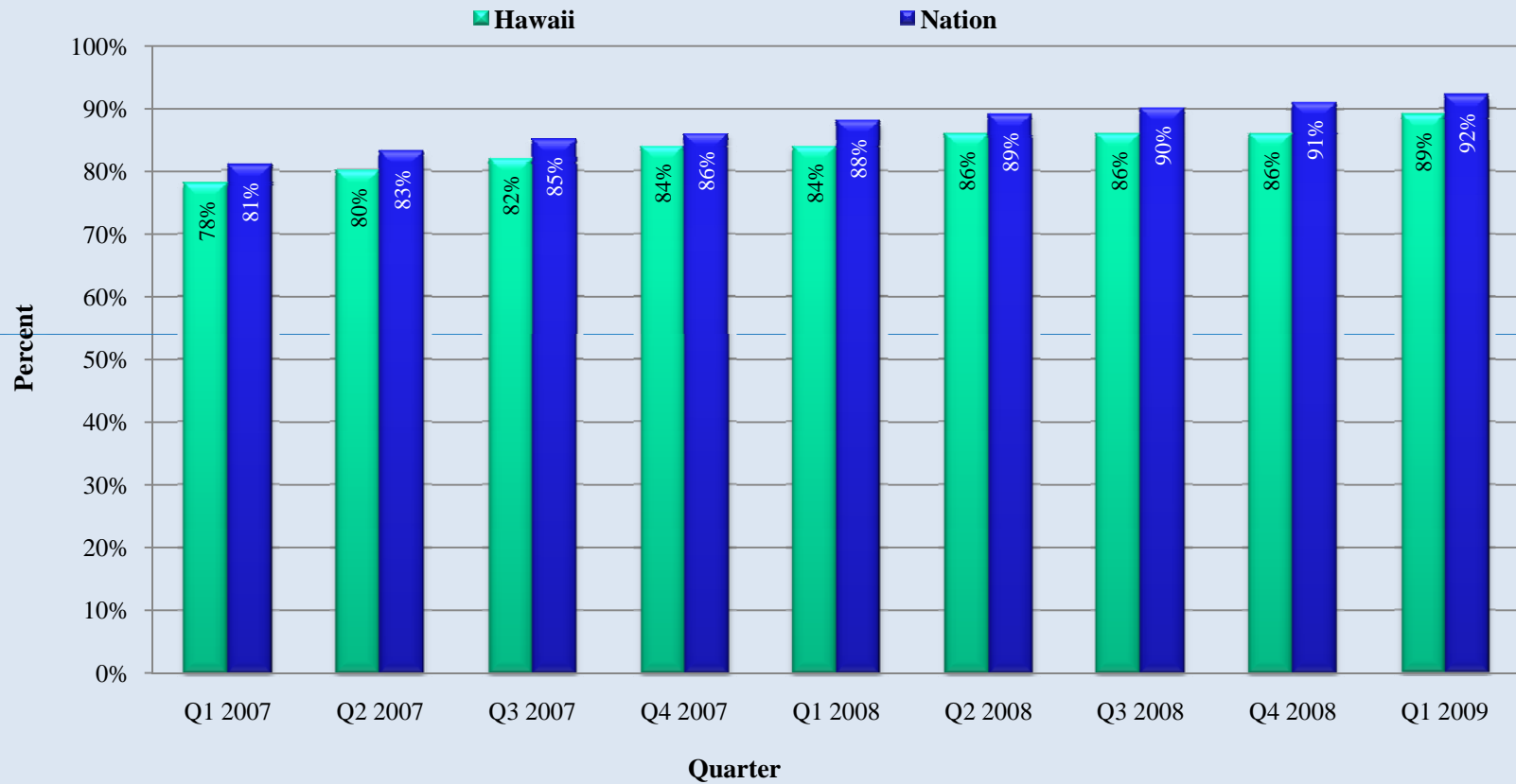
SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision



SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients

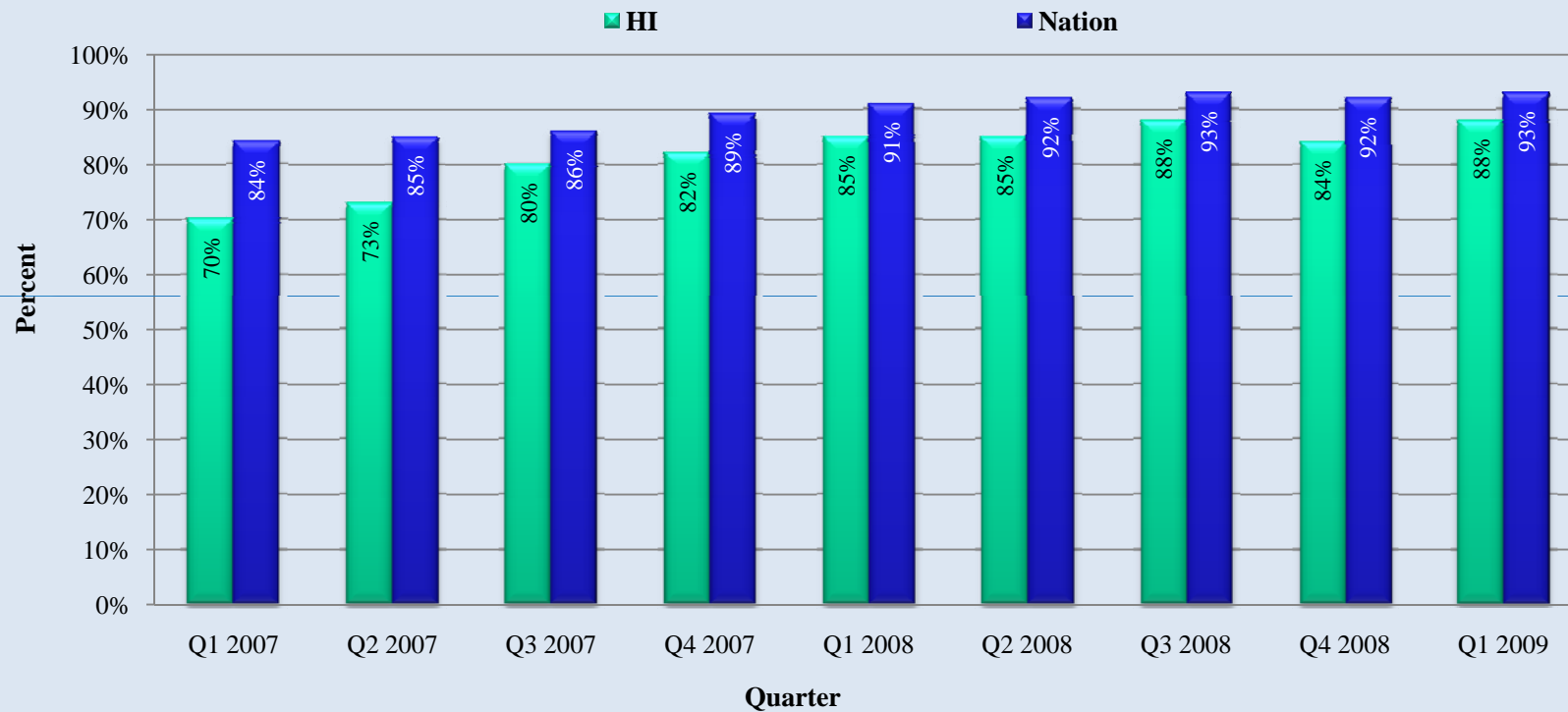


SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time

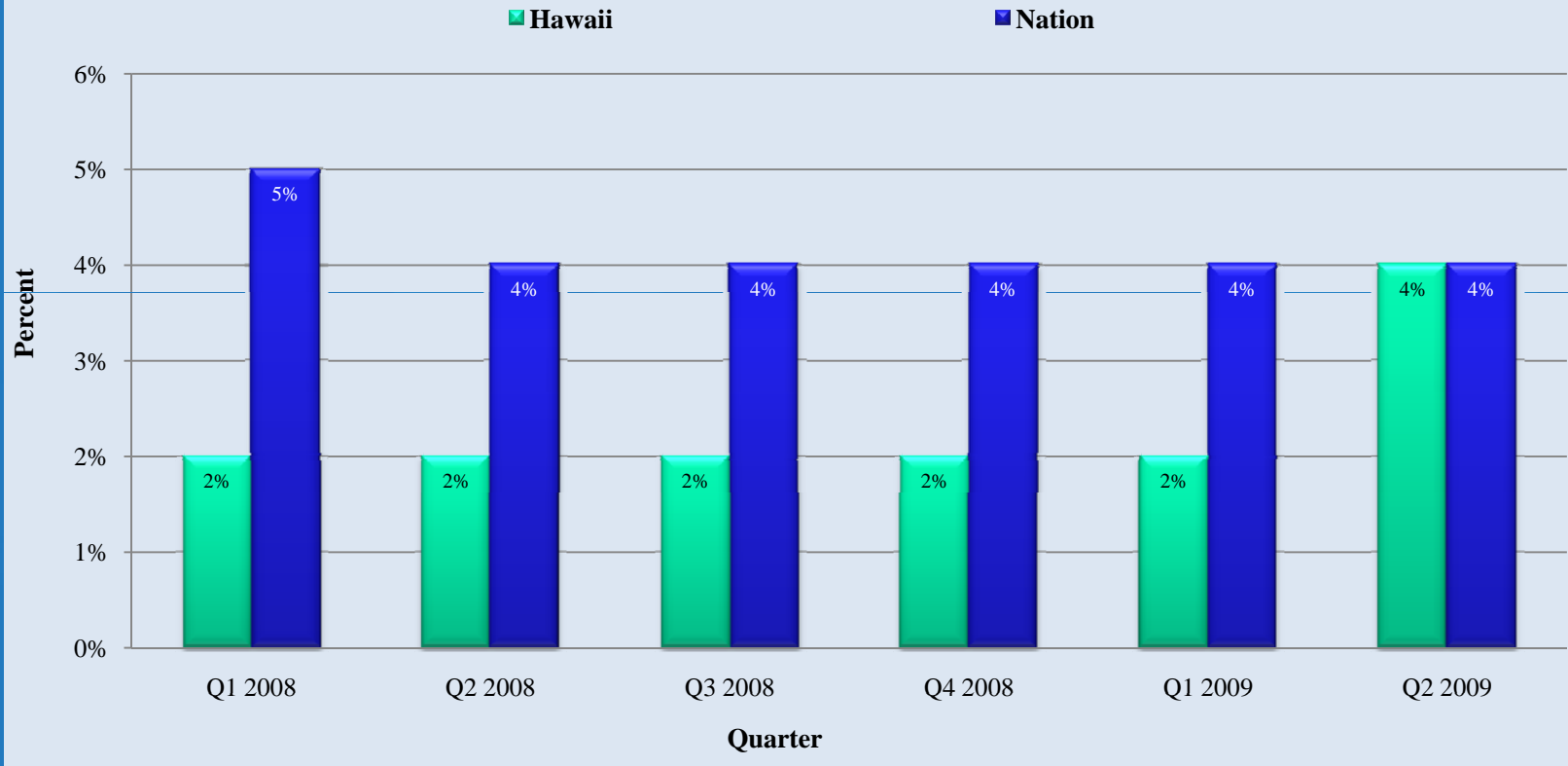


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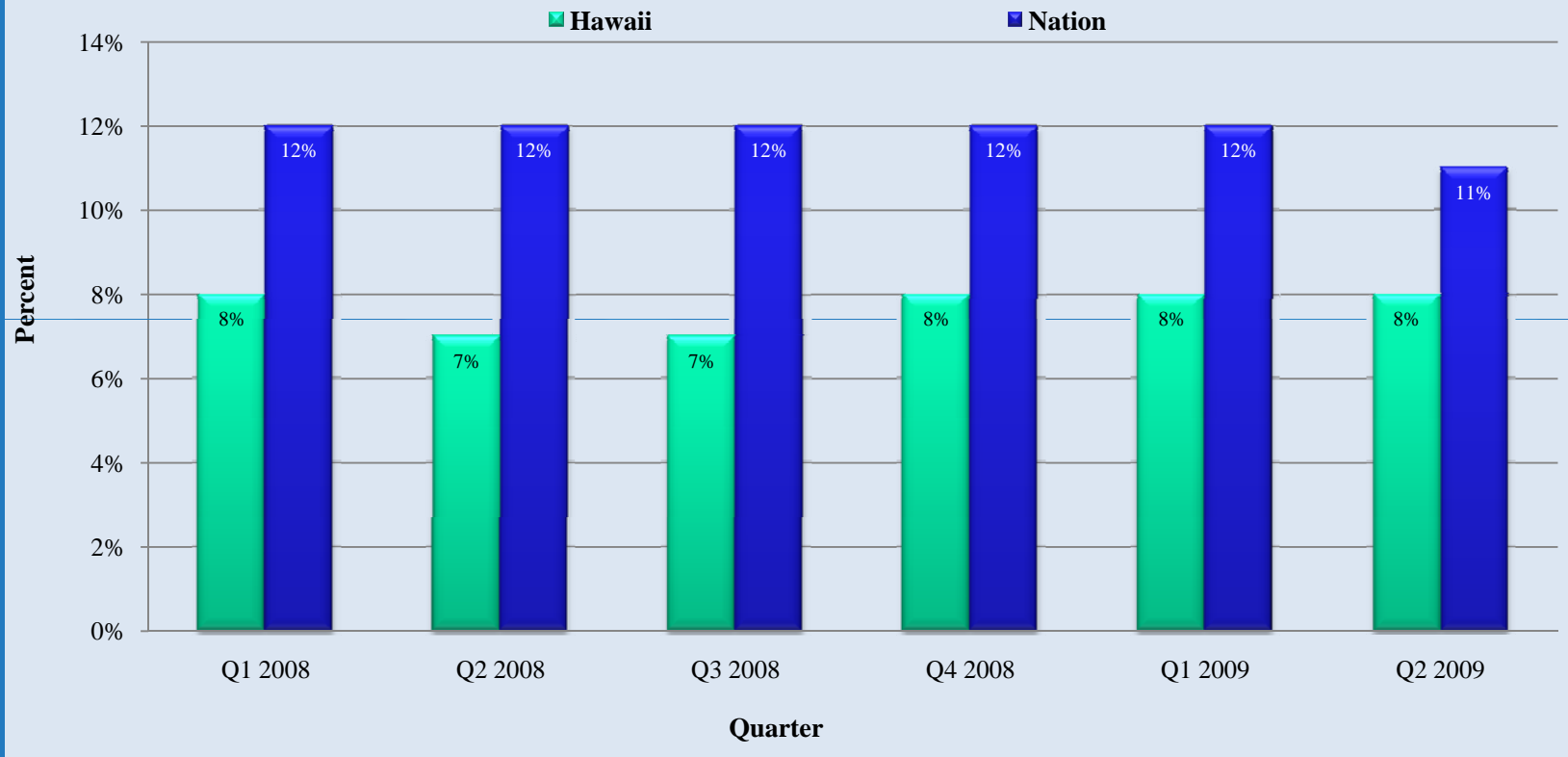
SCIP-VTE-1: Surgery Patients With Recommended Venous Thromboembolism Prophylaxis Ordered



Percent of Long-Stay Residents Who Were Physically Restrained



Percent of High-Risk Long-Stay Residents Who Have Pressure Sores



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Hospital Compare

- All hospitals are encouraged to sign-up for Hospital Compare.
- Transparency builds public trust in institutions that are valued and vital to the communities they serve
- The first step in quality improvement is having good information



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MedQIC

- www.medqic.org
- Excellent resource for quality improvement tools, presentations, literature for
 - Hospitals
 - Nursing homes
 - Physician offices



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Prevention Theme

- Recruit 10 physician practices
- Monitor statewide rates for...
 - mammograms,
 - CRC screenings,
 - influenza and pneumococcal pneumonia immunizations
 - disparities



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Cancer Screening

- Breast Cancer (Mammography)
 - Most common non-skin cancer in women
 - Second leading cause of cancer death in women in the U.S.
- Colorectal Cancer (CRC)
 - CRC is the third most commonly diagnosed cancer
 - Second most common cause of death in the U.S.
 - Lifetime risk of being diagnosed CRC is 5.9 percent in men and 5.5 percent in women
 - 91 percent of new cases occur in individuals older than 50
 - Incidence rate of CRC is more than 50 times greater in persons aged 60-79

Immunization

- Influenza
 - The best way to prevent the flu is getting a flu vaccination each year
 - Vaccine can be effective in preventing secondary complications
 - Reduce the risk of influenza-related hospitalization and death among adults ≥ 65 with and without high risk medical conditions (heart disease, diabetes)



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Immunization (cont'd)

- Pneumococcal disease
 - CDC reports incidence of invasive pneumococcal disease as greater than 50 per 100,000 in 65 and older population
 - Medicare pays for one vaccination each year
 - One vaccination at age 65 generally provides coverage for a lifetime
 - For some high-risk individuals a booster is needed
 - Medicare pays for booster for high-risk individuals if five years have passed since their last vaccination



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QIO/CMS Future Plans

- 1. RACs – Coming soon
- 2. ICD-10/HIPAA code sets
- 3. Health Information technology
 - Health Information Exchange
 - HIT Regional Extension Centers
- 4. Value- Based Purchasing
- 5. Incentive Payments / Disincentive Payments



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ICD-10 CM/PCS Transition

- Compliance date: October 1, 2013
- Education Timeline -
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_043249.hcsp?dDocName=bok1_043249
- Emphasis on the need for advanced biomedical science courses – anatomy, physiology, pathophysiology, pharmacology, and medical terminology.
- Training for experienced coders - focus on continuing education



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More on ICD-10

- Estimated to cost small physician office practice \$84,000 to make the transition.
- Must be done – ICD-9 is 30 years old
- Will enhance value based purchasing



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Health Information Technology

- American Recovery and Reinvestment Act
- Title XIII of Division A Health Information Technology
- Title IV of Division B Medicare and Medicaid Health Information Technology



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HITECH

- Together equal the:
- Health Information Technology for Economic and Clinical Health Act
or
- HITECH ACT



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Incentive Payments

- Meaningful Use of an EMR
- *Criteria still in development:*
- See Office of the National Coordinator site for the latest proposal from the Policy Council for definition.



Meaningful Use

- Generally:
 - Certified Electronic Health Record
 - Electronic exchange of health information to improve the quality of health care
 - Includes reporting on clinical quality using the EMR



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Incentives

- Funds distributed through Medicare and Medicaid
- Begins 2011
- Applied to 75% of Medicare allowable charges for covered services provided during the year.



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Maximum Payments

- 2011 \$15,000
- 2012 \$12,000
- 2013 \$8,000
- 2014 \$4,000
- 2015 \$2,000
- 2016 \$0



HPSA add-on

- Providers in predominantly furnish services in a health professional shortage area (HPSA) there will be an additional 10% bonus paid



Disincentives

- Eligible providers who are not meaningful users of EMRs
- 2015 - 1%
- 2016 - 2%
- 2017 - 3%
- Beyond -3 to 5%



2018 and beyond

- If proportion of eligible providers who are meaningful users is less than 75% then the reduction will be increased by 1% per year up to 5% maximum.



Hospital Incentives

- Subsection d and Critical Access Hospitals
 - Same timelines 2011 to 2015
 - Payment is the product of:
An initial amount, the Medicare share, a transition factor.
Initial Amount: \$2,000,000 plus \$ amount based on number of discharges for each hospital

Medicare Share

- Estimated Medicare fee for services and managed care bed days
-
- Total inpatient bed days modified by charges for charity care



Critical Access Hospitals

- Reasonable costs for the purchase of certified EMR technology computed by expensing such costs in a single payment year rather than depreciating them.
- Incentive payments same as above plus 20% not to exceed 100%.
- Prompt interim payments



Disincentives

- Market basket adjustments for hospitals that are not meaningful users
- Secretary may offer a significant hardship exemption

Health Information Exchange

- Office of the National Coordinator Grants
- State or State-designated entity apply
- \$564,000,000 for four years



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HIE Purpose

To continuously improve and expand HIE services to reach all health care providers in an effort to improve the quality and efficiency of health care.



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HIE Goals

- Development of governance, policies, technical services, business operations and financing mechanisms over four years.
- Expected to coordinate regional and statewide exchanges moving toward national interoperability



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HIT Regional Extension Centers

- Office of the National Coordinator Grant
- Competitive Process
- Regions not defined
- Must be able to serve 1,000 priority primary care practitioners



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Priority Primary Care Providers

- Practitioners who can prescribe (MD, DO, NP, PA)
- In primary care practice (PC, IM, Ped, OB/GYN,)
- In offices of less than 10 practitioners
- Associated with CAH/CHC/FQHC
- Serving uninsured/underinsured/



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Goal

- To have 1,000 PPCPs using certified electronic medical records in a manner that meets meaningful use criteria within two years, beginning January 15, 2010.



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Funding

For the first two years:

- Grant pays 90% of the consultation costs
- Recipient pays 10%

For the next two years:

- Grant pays 10%
- Recipient pays 90%



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Value Based Purchasing

Programs could include:

- Accountable Care Organizations
- Public Reporting of Cost and Quality Data
- Payments adjusted to account for variations in costs and utilization (Dartmouth)



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More Future Plans

- QIO Future Plans
- (Just reading the tea leaves)
- Current Activities expected to continue
- ADD:
 - Coordination of Care Program



Coordination of Care

- Focus is on the patient during transitions
- Program provides increased communication, monitoring, education for caregivers
- Result is up to 50% reduction in re-hospitalization



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Questions?

This information is brought to you by Mountain-Pacific Quality Health, the Medicare quality improvement organization for MT, WY, HI and AK, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy.
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