“Physician Payments Sunshine Act”
Affordable Care Act § 6002
and Updates on Value Based Purchasing

Health Watch USA
Healthcare Transparency &
Patient Advocacy
Lexington, Kentucky
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Richard E. Wild, MD, JD, MBA,
FACEP

Chief Medical Officer, Atlanta
Regional Office

Centers for Medicare & Medicaid Services
Program Integrity encompasses a range of activities to target the causes of improper and fraudulent payments:

- **Mistakes**: Examples: Incorrect coding
- **Inefficiencies**: Examples: Medically unnecessary service
- **Bending the rules**: Examples: Improper billing practice (e.g., up-coding)
- **Intentional Deception**: Examples: Billing for services or supplies that were not provided
“Physician Payments Sunshine Act”
AFFORDABLE CARE ACT § 6002

OPEN PAYMENTS
CREATING PUBLIC TRANSPARENCY
OF INDUSTRY-PHYSICIAN
FINANCIAL RELATIONSHIPS

http://go.cms.gov/openpayments
Innovation vs. Conflicts of Interest

Interactions between medicine and industry have a wide spectrum of purposes and resulting impacts.

Collaboration may promote discovery and development of new technologies that improve individual and public health.

Financial ties may create conflicts of interest across all aspects of medicine: clinical practice, clinical and basic science research, medical education, standard setting, and medical publications.
Of the physicians in the U.S.:

- More than 25% are paid by industry for consulting, giving lectures, or enrolling patients in clinical trials.
- 75% have received food or drug samples from drug manufacturers.

Estimated 1.6M transactions accounting for more than $1 billion annually.

Physician-driven discretionary spending accounts for up to 60% of total health care costs.
Applicable manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid, or CHIP shall report annually to CMS certain payments or transfers of value provided to physicians or teaching hospitals.

Applicable group purchasing organizations (GPOs) and manufacturers are required to annually report certain physician and close family ownership/investment interests.

The Secretary is required to publish submitted payment and ownership information on a public website.
• Rule covers all physicians (SSA §1861(r) definition) whether Medicare/Medicaid enrolled or not

• Any entity producing or distributing even one product covered by Medicare, Medicaid, or CHIP is an applicable manufacturer – for all of their products

• Requires reporting of form (e.g. cash, stock) and nature of payment (e.g. travel, honoraria)

• Publication of certain research, development, and clinical investigation payments can be delayed up to four years
2013 Program Cycle

**Industry will:**
Collect information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their family members

**August – December 2013**

**Physicians should:**
Keep track of payments and transfers of value made to you and be mindful of ownership and investment interests held by you and your family

**Industry will:**
Register and submit 2013 information to CMS

**1Q 2014**

**Physicians should:**
Register with CMS in order to receive notifications and information submitted by the industry

**Industry will:**
Correct disputed information

**2Q 2014**

**Physicians should:**
Review your information for accuracy

**CMS Public Website:**
2013 Information Posted

**Sep 2014**
Core Business Functions

1. Registration
2. Submission & Attestation
3. Review & Dispute
4. Dispute Resolution
5. Publication
6. Audit

Submitters
- Applicable Manufactures & GPO’s

Reviewers
- Physicians & Teaching Hospitals
Mobile Applications

- CMS has created two free mobile applications to aid physicians and industry in tracking data collected for Open Payments
  - Open Payments Mobile for Physicians
  - Open Payments Mobile for Industry
- Applications are available for Apple (iOS) and Android
- Benefits include:
  - Provides a tool to track payments and transfers of value in real-time.
  - Serves as a reference tool during review or information disputes
  - Allows physician to provide accurate profile information to industry
  - Minimizes the risk of data mismatches when submitted by industry
  - Allows physicians to receive event and payment or other transfer of value, and profile information from industry
Apps Exchange Information for Easier Data Collection

Physician App

Send Profile Information

Industry App

Send Profile Information

Send Payment Information

QR Code
How to Get More Information

- We are providing easy to understand information about OPEN PAYMENTS to physicians

  - Webpage dedicated to physicians
  - Fact Sheets specific to physicians
  - Continuing Medical Education modules (2)
  - Brochure summarizing OPEN PAYMENTS for physicians
  - Brochure summarizing OPEN PAYMENTS for patients
CPI Has Developed Educational Materials on Numerous PI Topics

- Beneficiary card sharing
- Drug diversion
- Managed Care compliance
- Pediatric Dental Compliance
- Durable Medical Equipment
- Home Health
- Medical identity theft
CME Activities

Over 20,000 CME hours granted:

- **How CMS Is Fighting Fraud: Major Program Integrity Initiatives** (Medscape)
- **Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients** (Medscape)
- **Are You Ready for the National Physician Payment Transparency Program?** (Medscape)
- **The Physician Payment Transparency Program and Your Practice** (Medscape)
- **Safeguarding Your Medical Identity** (Medicare Learning Network)
http://go.cms.gov/openpayments

http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html
We need delivery system and payment transformation

**Current State –**
- Producer-Centered
- Volume Driven
- Unsustainable
- Fragmented Care Systems
- FFS Payment Systems

**Future State**
- People-Centered
- Outcomes Driven
- Sustainable
- Coordinated Care Systems

**New Payment Systems**
- Value-based purchasing
- ACOs Shared Savings
- Episode-based payments
- Care Management Fees
- Data Transparency
Value-Based Purchasing

- Goal is to reward providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.
- Hospital value-based purchasing program shifts approximately $1 billion based on performance.
- Five Principles
  - Define the end goal, not the process for achieving it
  - All providers’ incentives must be aligned
  - Right measure must be developed and implemented in rapid cycle
  - CMS must actively support quality improvement
  - Clinical community and patients must be actively engaged

VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012
Discussion

● Our Goals and Early Results

● Value-based purchasing and quality improvement programs

● Center for Medicare and Medicaid Innovation

● Quality Measurement to Drive Improvement

● Future and Opportunities for collaboration
The Six Goals of the National Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable
CMS framework for measurement maps to the six national priorities

- Measures should be patient-centered and outcome-oriented whenever possible

- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures

**Care coordination**
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

**Clinical quality of care**
- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

**Person- and Caregiver-centered experience and engagement**
- CAHPS or equivalent measures for each setting
- Shared decision-making

**Population/ community health**
- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

**Efficiency and cost reduction**
- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

**Safety**
- Healthcare Acquired Infections
- Healthcare acquired conditions
- Harm
CMS has a variety of quality reporting and performance programs, many led by CCSQ

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<th>Hospital Quality</th>
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<th>PAC and Other Setting Quality Reporting</th>
<th>Payment Model Reporting</th>
<th>“Population” Quality Reporting</th>
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Medicare All Cause, 30 Day Hospital Readmission Rate

Source: Office of Information Products and Data Analytics, CMS
Over 1,000 ICUs achieved an average 41% decline in CLABSI over 6 quarters (18 months), from 1.915 to 1.133 CLABSI per 1,000 central line days.
Partnership for Patients: Hospitals Continue to Generate Increases in Reporting, Improvement and Achievement on More Harm Areas

- Reporting on 5 or More HACs
- Improving on 5 or More HACs
- Showing Benchmark Status on 5 or More HACs
Results: Medicare Per-Capita Spending Growth at Historic Low

Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget
We are starting to see results nationally

Cost trends are down, Outcomes are Improving & Adverse Events are Falling

- Total U.S. health spending grew only 3.9 percent in 2011
- Medicare trend over 3 years at historic lows - +.4% in 2012
- Medicaid spending per beneficiary has decreased over last two years - .9% and .6% in 2011 and 2010
- Pioneer model with early promising results, Partnership for Patients
- Expanding coverage with insurance marketplaces gearing up for 2014
Our Ask:

● Continue the work of improving quality and patient safety
● Support the National Quality Strategy & the Partnership for Patients
● Push your organizations to support this transition to a sustainable patient centered healthcare system
● Chose Your Pathways and Participate in Alternative Payment Models:
  ○ ACOs, Models focused on Primary Care, Bundled Payments for Care Improvement, State Innovation Models, etc
● Make your personal commitment to transformation
Questions and Discussion

Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer, Atlanta Regional Office
Centers for Medicare and Medicaid Services (CMS)
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303
richard.wild@cms.hhs.gov