14-104  Review of Physician Quality Reporting Initiative

Strategic Area:  Financial/Operational  
Risk Type: Financial, Operational, Compliance  
Audit Manager:  Veronica Kasdorf

Overview:

At the request of the UT System Office of Health Affairs, Internal Audit completed a review of MD Anderson’s efforts to comply with guidelines for the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS). This consulting engagement was performed to provide a perspective of existing PQRS operations at each UT Health institution. It also serves to satisfy the requirement of the annual audit of the Physician Referral Service Faculty Practice Plan (PRS Plan). Appendix A outlines the objective, scope and methodology for the project.

PQRS is a tool developed by the federal government to collect meaningful data that will help lead to improved patient care. It also reflects CMS’s goal of shifting toward Medicare reimbursements that reward value rather than volume. PQRS uses a combination of incentive payments and payment adjustments (penalties) to promote reporting on quality measures for services furnished to Medicare Part B Fee-for-Service beneficiaries.

To avoid more than $1 million in penalties for non-participation, MD Anderson began participating in PQRS in 2013. PQRS was difficult to fully apply in 2013, as this was the first year that MD Anderson had a portion of its Medicare reimbursement tied to quality reporting. MD Anderson, along with 10 other free-standing cancer centers, have historically been exempt from hospital-based mandatory reporting programs, such as the Inpatient Quality Reporting (IQR) program. Because most CMS quality programs have been developed for hospitals and providers that treat a variety of diseases, the measures included in these programs are not focused on cancer treatment and are not well-suited for reporting by the free-standing cancer centers.

As a result, the Institution selected the administrative claims option for PQRS in 2013. This option was selected based on management’s detailed analyses and comparisons of costs and potential penalties associated with other available reporting options. Under the administrative claims option, CMS will analyze Medicare claims for calendar year 2013 to calculate the Institution’s clinical quality based on a specific set of measures. Although the Institution avoided a penalty by selecting the administrative claims option, it also waived a PQRS incentive payment of 0.5% of the total allowed charges for Medicare Part B professional services provided during 2013, totaling approximately $221,000.

At the time of our review, the Institution was evaluating the PQRS reporting options that are available for 2014. Within the next few months, management will be better positioned to make a final decision on the reporting option to use, as well as the possible quality measures that will be reported. Meanwhile, the Institution is continuing its ongoing efforts to...
improve the quality and safety of patient care beyond PQRS. This includes clinical data capture, analysis, and reporting services related to more than 1,600 internal and federally-mandated quality measures through the Office of Performance Improvement. Additionally, we are collaborating with various external organizations to develop cancer-specific quality measures for potential use in federal reporting, benchmarking, and internal quality improvement.

See the Results section of this report and related Appendices B through D for additional details of our review.

Results Summary:

Based on our review, key individuals are aware of the requirements and responsibilities related to PQRS. For 2013, reasonable analyses were performed to select the most cost-effective reporting approach for the Institution, and the same thoughtful approach is being utilized to determine the best method for the future.

Number of Priority Findings to be monitored by UT System: 0

A Priority Finding is defined as “an issue identified by internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.”

We sincerely appreciate the courtesy and cooperation extended to us by the Office of Performance Improvement (including Quality Measurement and Engineering); Office of the EVP/Physician-in-Chief; Office of the SVP/Chief of Clinical Operations; Clinical Revenue and Reimbursement; and Physicians Referral Service.

Sherri Magnus, CPA, CIA, CFE, CRMA
Vice President & Chief Audit Officer
July 29, 2014
Background

In 2007, the Centers for Medicare and Medicaid Services (CMS) established the Physician Quality Reporting Initiative (PQRI), as required by the 2006 Tax Relief and Health Care Act. This initiative established financial incentives to motivate eligible healthcare professionals to participate in voluntary quality reporting on Medicare Part B fee for service claims. The Medicare Improvements for Patients and Providers Act of 2008 made the PQRI permanent, with incentive payments authorized through 2010. With passage of the Patient Protection and Affordable Care Act of 2010, CMS renamed this program the Physician Quality Reporting System (PQRS).

To encourage reporting of quality measures, CMS has provided incentives for eligible providers and physician groups. For 2013, eligible providers, individually or as a group, could have earned bonus payments of 0.5% of the total allowed charges for Medicare Part B professional services provided during the period. Though voluntary for calendar year 2013, not reporting PQRS measures could have resulted in a 1.5% penalty against the 2015 physician fee schedule. This penalty will increase to 2% in subsequent years. Not reporting could also result in an additional 1% to 2% reduction against the fee schedule.

Groups, such as MD Anderson, with more than 100 eligible providers that bill Medicare for Part B services under a single tax identification number, had four options for reporting PQRS measures to CMS for 2013:

1. CMS-provided Group Practice Reporting Option (GPRO) Web Interface
2. Approved third-party registry
3. CMS calculation of group performance based on 2013 administrative claims
4. Submission of quality data on individual claims for up to three measures

CMS did not provide any incentive for groups that selected option three, the administrative claims option.
Results

1.0 PQRS History at MD Anderson and Reporting Methodology for 2013

Calendar year 2013 was MD Anderson’s first year of PQRS participation, so no past incentives on Medicare Part B billing were received. According to management, the Institution began participating in 2013 because the cost of participating in prior years would have been greater than the incentives that were available. This is due to the investment required for making programming changes to the Institution’s billing system or enlisting contract workers to extract data from medical records for reporting on the required PQRS performance measures.

Furthermore, 2013 was the first year for which non-participation penalties would be imposed. The penalties for 2013 would be assessed in 2015, and could total more than $1 million for the Institution, based on net provider Medicare Part B revenue of $44.2 million for the year. According to management, the Institution employed a penalty-avoidance strategy in 2013 and selected the administrative claims option, which was the simplest and least risky reporting option available.

Management performed an analysis which concluded that other options, such as the Group Practice Reporting Option (GPRO) and the Individual Claims option, would require implementation costs of at least $700,000 to hire temporary staff or make programming changes to gather data for each of the relevant performance measures. According to management, these implementation costs would yield a low return on investment and outweigh the benefit of any penalty avoided. See Appendix B for management’s cost analysis.

In addition, certain PQRS methods require public reporting of quality results that were based on measures that are not cancer-specific and do not apply to MD Anderson and the types of services it provides. These results would depict the Institution’s services as having high cost and low quality, which poses a reputational risk to the organization. Under the administrative claims method, quality results derived from CMS’s review of the Medicare claims data will not be reported publicly.

2.0 PQRS at MD Anderson in the Future

At the time of our review, the Institution was evaluating the PQRS reporting options available for 2014. The challenge is to identify the most-cost effective approach that will yield quality results based on measures that are the most meaningful and relevant to the Institution’s operations.

CMS has not yet published the election deadlines for all of the available PQRS reporting options in 2014. However, management is optimistic about the ability to obtain data for reporting and is exploring the feasibility of a data repository for this purpose. In addition, the Institution has demonstrated preparedness for future PQRS reporting by appointing a
committee to provide governance for all quality measures that impact reimbursement or are publicly reported.

3.0 Oversight and Monitoring of Quality and Safety beyond PQRS

MD Anderson has extensive processes for monitoring the quality and safety of patient care beyond PQRS. These processes are managed by the centralized Office of Performance Improvement (OPI), which is responsible for providing education and resources to improve and ensure the quality and safety of care provided to the Institution’s patients. The office includes Quality Measurement & Engineering (QM&E), which provides expertise and data to achieve organizational process and system improvements. QM&E includes Clinical Operations Informatics (COI), which compiles and reports data for more than 1,600 measures to track quality within the Institution. These measures come from a variety of sources, such as the National Surgical Quality Improvement Program of the American College of Surgeons, the University Healthcare Consortium and the Centers for Medicare and Medicaid Services (based on reporting requirements outlined in the Affordable Care Act). The various sources and related measures are discussed in detail at Appendix C.
Appendix A

Objective, Scope and Methodology:

The objective of this review was to gain an understanding of the Institution’s efforts for reporting Physician Quality Reporting System (PQRS) measures to the Centers for Medicaid and Medicare Services (CMS) for calendar year 2013.

Procedures included, but were not limited to:

- Review of background information provided by UT System, CMS and institutional management to understand PQRS
- Interviews and review of documentation to understand and assess the reasonableness of the PQRS reporting mechanism chosen by the Institution for 2013 and the rationale for the selection
- Validation of certain financial information provided by management related to PQRS
- Interviews to determine the level of management oversight and monitoring related to PQRS measures
- Interviews and review of documentation to understand management’s oversight and monitoring of quality measures beyond the PQRS measures
- Interviews to understand the Institution’s evaluation of PQRS reporting options available in the future

Our review was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.
Appendix B

Cost Analysis for 2013 PQRS Reporting Options

The table below represents management’s analysis for determining the appropriate PQRS reporting method for 2013. The analysis shows the administrative claims option (which the Institution selected for 2013) would result in the lowest cost and greatest return on investment for the Institution.

<table>
<thead>
<tr>
<th></th>
<th>Administrative Claims Option</th>
<th>GPRO Option</th>
<th>Individual Claims Option¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COST TO IMPLEMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Unaudited)</td>
<td>0</td>
<td>$704,000</td>
<td>$704,000</td>
</tr>
<tr>
<td><strong>2015 Penalty</strong>²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1.5% PQRS adjustment and 1.0% value based payment adjustment to net Medicare payments)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Potential 2015 Penalty Avoided</strong></td>
<td></td>
<td>$1,060,719</td>
<td>$1,060,719</td>
</tr>
<tr>
<td>(1.5% PQRS adjustment and 1.0% value based payment adjustment to net Medicare payments)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net to the Institution</strong></td>
<td></td>
<td>$1,060,719</td>
<td>$356,719</td>
</tr>
<tr>
<td>(potential penalty avoided minus cost to implement)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Potential Incentive</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(.5% of net Medicare payments)</td>
<td>0</td>
<td>$220,923</td>
<td>$220,923</td>
</tr>
<tr>
<td><strong>Total Net to the Institution</strong></td>
<td></td>
<td>$1,060,719</td>
<td>$577,642</td>
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<tr>
<td>(potential incentive plus overall net)</td>
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</tbody>
</table>

**Source:** Information in this table is based on implementation costs and analysis methodology provided by Clinical Operations Informatics and net Medicare Part B payments for 2013 provided by Physicians Referral Service.

¹ According to management, the implementation costs for the Individual Claims option would be at least as much as the costs for the Group Practice Reporting Option (GPRO).

² Penalties will be assessed in 2015 based on reporting for calendar year 2013.
Appendix C

MD Anderson’s Quality Measures beyond PQRS

According to management, data for more than 1,600 measures is currently being compiled and reported through MD Anderson’s Office of Performance Improvement (OPI) to track clinical quality within the Institution. These measures were derived from the following entities and initiatives:

- **Ongoing Professional Performance Evaluation (OPPE)** - OPPE is the process by which the Institution reviews clinical performance indicators on an ongoing basis to identify and analyze individual clinical performance, ensure quality of patient care and implement corrective actions, as necessary. OPI assists the chair and quality officer of each medical department in designing specific quality metrics that are relevant to their specific practices. The metrics are presented to the OPPE subcommittee for approval. When the metrics are approved, the Clinical Operations Informatics (COI) team coordinates with relevant areas throughout the institution to obtain information for the metrics. Raw data related to the metrics is tracked, analyzed and compared within the Statit Performance Indicator and Management Dashboard. Statit allows for the creation of performance dashboards or profiles for each provider, and each profile is examined every six months by the relevant department quality officer to assess and approve the providers’ performance or recommend corrective action.

- **National Surgical Quality Improvement Program of the American College of Surgeons (NSQIP)** – For several years, OPI has worked with the Institution’s Department of Surgery to implement NSQIP. In this program, three specially-trained nurses and a medically-trained manager measure the quality of surgical outcomes over time by reviewing a sample of surgical cases based on a set of criteria issued by American College of Surgeons. Data from the cases is entered into a nationwide tracking database. The data is ranked nationally according to specific risk-adjustment criteria and provides comparative information related to mortality, morbidity, complications and other areas. The data also provides an overview on the Institution’s quality of medical care.

- **University Healthcare Consortium (UHC)** - UHC is a coalition of academic medical centers and their affiliated hospitals. It offers a variety of performance improvement products, including databases that provide comparative data in clinical, operational, faculty practice management, financial, patient safety, and supply chain areas. OPI sends MD Anderson’s medical claims data to UHC, and summary information is compiled related to the diagnoses and treatment of the Institution’s patients. The information is risk-adjusted and quality rankings are assigned based on specific risk models. UHC’s results are uploaded to the Institution’s Enterprise Information Warehouse, where the data is used to track patient safety events, create dashboards or scorecards, and provide departmental performance information to clinicians and administrators. UHC data is in the Institution’s patient safety dashboard and is monitored by OPI and the MD Anderson Patient Safety Committee.

- **Affordable Care Act** – COI is responsible for the collection and submission of data related to three oncology-specific measures that are associated with Affordable Care Act.
mandates. The data is submitted quarterly to the Centers for Medicare and Medicaid Services through the Rapid Quality Reporting Systems (RQRS), which is owned by the American College of Surgeons. The data is then placed into reports or dashboards for the Institution, as required.

- **Banner/MD Anderson Initiative** – The Banner MD Anderson Cancer center is an extension of MD Anderson, located in Arizona. COI works with the Banner/MD Anderson Initiative to measure quality care at the Arizona and Houston facilities. Quality is measured based on data that is extracted by COI related to eight breast cancer metrics, patient satisfaction information and colon cancer information. The quality results are recorded in a local database, included in COI reports and reported through the MD Anderson Physicians Network.

- **Patient Satisfaction Surveys** – COI works with Press Ganey to derive quality information based by gathering and reporting on MD Anderson’s patient satisfaction efforts. COI provides Press Ganey with contact information for inpatients and outpatients, and surveys are sent. Information received from the surveys by Press Ganey is reported to key clinical leaders across the Institution. COI also uses the survey data to create indicators showing patient responses across centers and inpatient units. These indicators are then displayed in Statit.
Appendix D

Additional PQRS Information

Potential Total Penalty for PQRS and Value-Based Payment in 2013
$1.06 million (1.5% PQRS adjustment of $662,768 and 1.0% value-based payment adjustment of $397,951)

Title of Position Charged with PQRS Management:
Vice President, Performance Improvement

Maturity of PQRS Operation:
New

Method of PQRS Reporting in 2013:
Administrative Claims

Scope of PQRS Coverage:
Through the administrative claims option, CMS will calculate quality performance based on Medicare Part B fee-for-service claims submitted in 2013 for all eligible providers.

Are PQRS Results Utilized Internally?
According to management, there will likely be little value in the PQRS results for 2013 once they are received from CMS because the metrics evaluated are not specific to cancer care. We will, however, review this information to evaluate potential opportunities in our non-oncology patient care protocols and practices. MD Anderson currently relies on other metrics in its ongoing Performance Improvement program that are more useful and relevant to its operations.