University Hospitals

Quality, Healthcare Reform & Change

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Sawmill Creek

William L. Annable, M.D.
Chief Quality Officer & Director
University Hospitals Quality Institute

Agenda:

I. National Quality Strategy

II. Quality Defined

III. Healthcare Reform

IV. Pay for Performance

   A. Inpatient Approach
      a) Value-Based Purchasing
      b) Readmissions
      c) Hospital Acquired Conditions
      d) Medicare Spending per Beneficiary

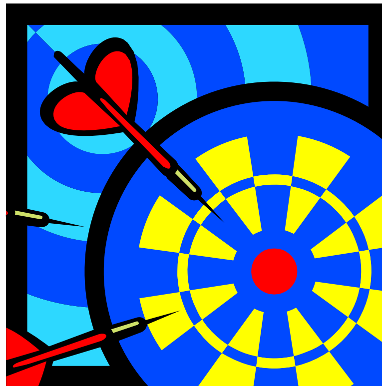
   B. Outpatient Approach

National Strategy for Quality Improvement in Health Care

Establishes a framework for coordinating and focusing the efforts of diverse stakeholders to improve healthcare.

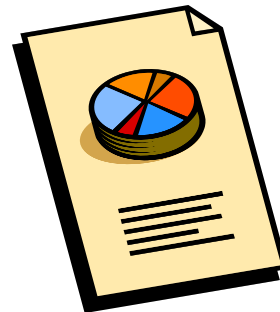
3 Aims:

- Better Care
- Healthy People/Healthy Communities
- Affordable Care



6 Strategies:

1. Reducing harm in care delivery
2. Engaging Patients
3. Improving communication and coordination of care
4. Promoting effective prevention and treatment
5. Working with communities to promote best practices
6. Making quality care affordable with new delivery models



National Strategy for Quality Improvement in Health Care

The National Strategy will help to align care delivery, payment incentives, and programming to drive improvement.

II. Quality Defined

Institute of Medicine

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Quality Defined (continued)

- The Institute for Healthcare Improvement "Triple Aim":
  - Improved health
  - Enhanced patient experience of care
  - Reduced cost
- National Quality Forum has endorsed more than 600 quality measures
- Hospitals provide 57 inpatient measures to the Joint Commission of Hospital Accreditation

UHCMC's Purpose in its Annual Quality Improvement Plan

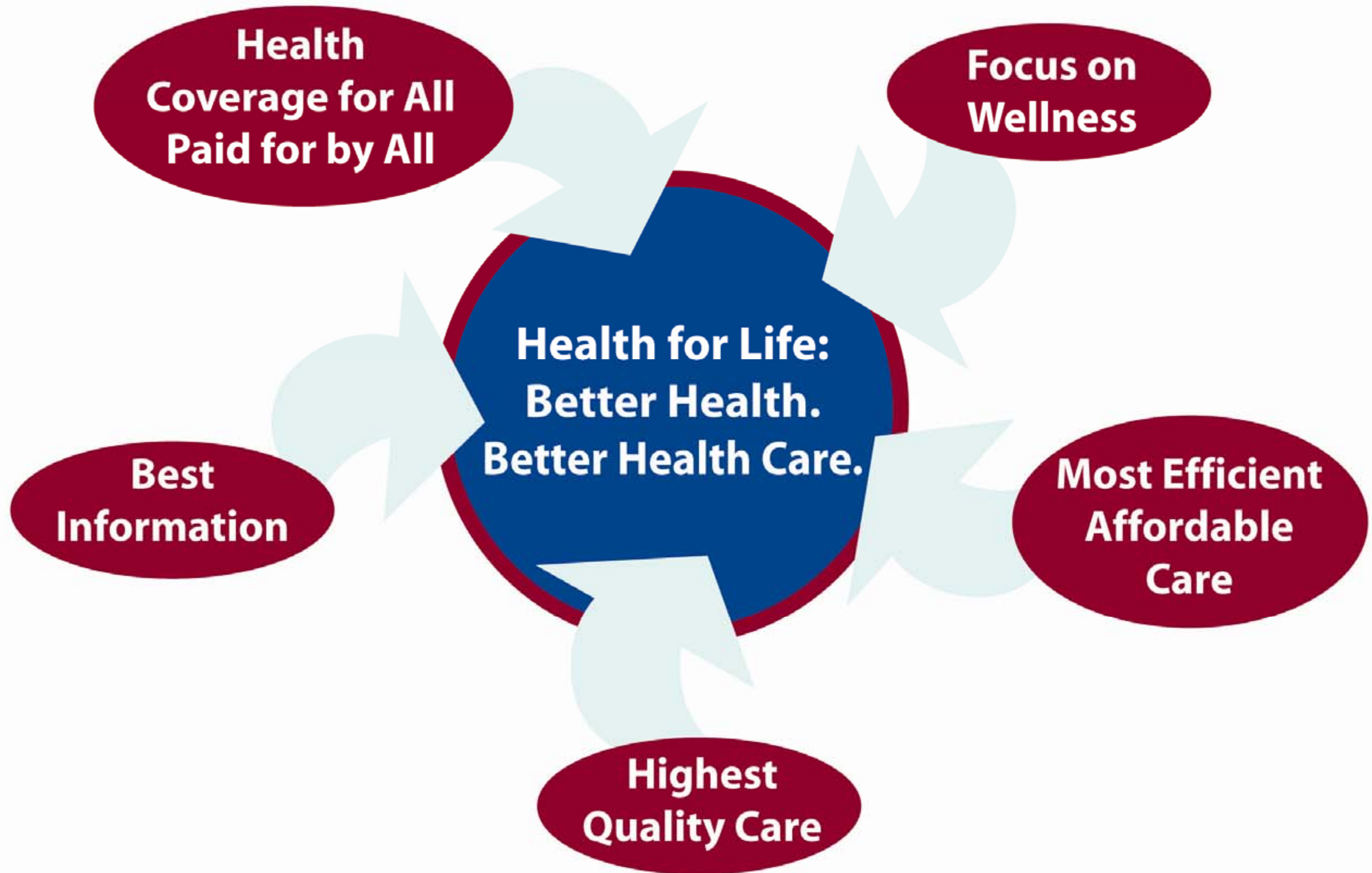
"To foster an environment in which our patients experience no needless deaths, no needless pain and suffering, no helplessness in those served or serving, no unwanted waiting and no waste."

III. Healthcare Reform

National Business Group On Health…

Health care, in the US, unlike all other industries is driven by perverse financial incentives by which consumers and physicians decide what healthcare might be needed or wanted and another totally separate party – the employer, insurer or government agency pays for that care after the fact.

National Framework for Change

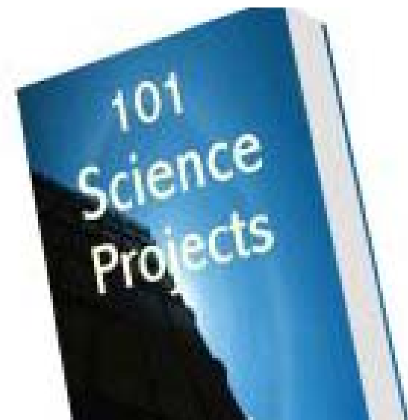


US Healthcare Reform & Quality:

- Covers 32 million currently uninsured
- Contains insurance market reforms
- Costs $940 billion (2010 – 2019)
- Creates Delivery system reform
- Patient incentives—wellness/prevention
- Waste, fraud and abuse provisions
- Align payment with quality

Reform and Quality:

- Quality Bonuses
- Compensation at Risk
- Tiered Networks
- Reduce administrative/other requirements
- Bundled Payments
- Not paying for never events
- Pay for Meeting Targets
- Pay for Demonstrating Improvement



Why is High Quality Good Business?

- Drives improvement
- What gets measured gets managed
- Quality becomes a scientific discipline
- Alignment of resources
- Identify disparities
- Creates imperative for change

ABC's of CMS

Medicare Part A

-Hospital Payments

-FICA

-UB04

-$200 Billion Annual Spending

-Inpatient Prospective Payment System

Medicare Part B

-Provider Payments

-Premium Based

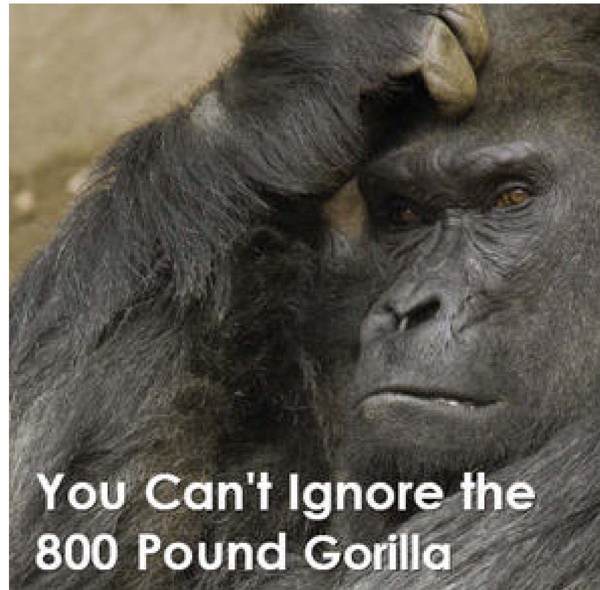
-Form 1500

-Provider Fee Schedule

-$120 Billion Annual Spending

CMS Influence:

- Largest payer for healthcare in US
  - 45 million beneficiaries
  - 50% of payer mix in most hospitals
- Sets national agenda for payment and policy



The Value Equation

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

IOM Crossing the Quality Chasm

"Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions."

IV. Pay for Performance

The 3 Worst Mechanisms for Rewarding Quality and Performance:

1. Fee-for-Service: rewards time and activity, penalizes reduced utilization.

2. Capitation: rewards efficiency, neutral on quality initiatives.

3. Salary: rewards stability, promotes bureaucracy.

Pay for Performance…What is it?

- Provider payment based on quality of care.
- “The Best Worst Choice” to balance provider autonomy with accountability needed for safe and high quality care.

The Goals of Pay for Performance:

- Redesign systems to improve quality and efficiency.
- Reduce errors
- Reduce costs
- Advance information technology
- Broaden delivery of care beyond the office
- Put direct responsibility on provider practices to “get it right the first time”

Stakeholder: Physicians

71% - Support payment based on quality.

90% - Current reimbursement does not reward for high quality care.

52% - Support public access for information about physician quality of care.

Stakeholder: Physicians
(Continued)

General Internists Views:

73% - Physicians should be given financial incentives for quality

32% - Quality of individual physicians should be made public

30% - Present measures of quality are generally accurate

Expert Consensus on Physician Pay for Performance

"There's no question that pay for performance will work."
Thomas Scully, CMS Administrator

"Evidence suggests pay for performance can work, but also can fail." *Meredith Rosenthal, Harvard School of Public Health*

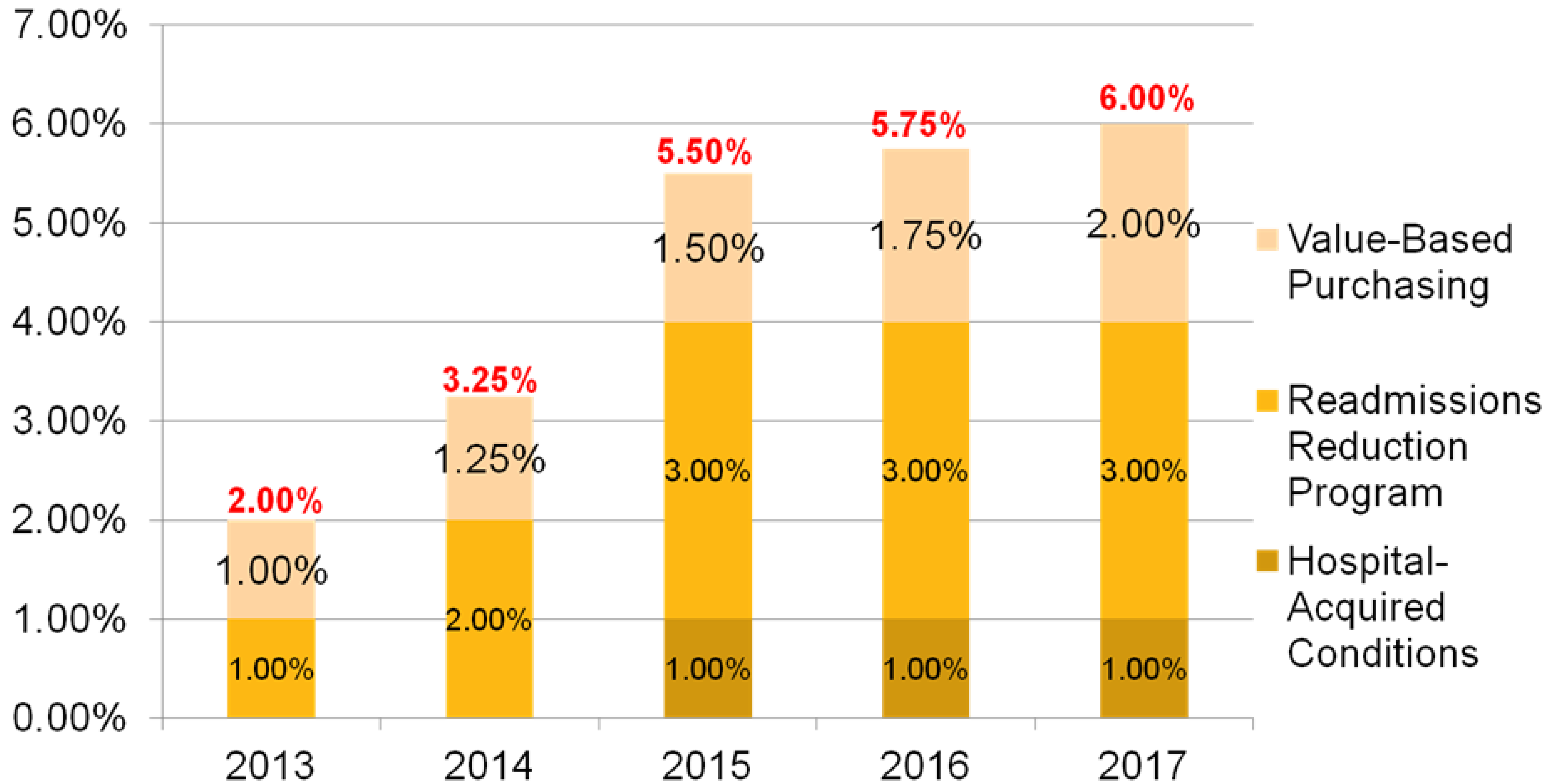
"I am always entranced when intelligent people became mesmerized by an idea that is patently stupid. Nowhere has this phenomenon been more in evidence than in the pay for performance mania that is absolutely sweeping the nation." *William G. Plested, former AMA President*

Inpatient Approach

3 Distinct Programs:

1. Value-Based Purchasing
2. HAC/AHRQ Program
3. Readmissions Reduction Program

Total Hospital Revenue At Risk From Major Medicare Quality Programs



Value to University Hospital*

1) Value-Based Purchasing -- $20 million over 6 years

2) Readmissions -- $15 million to UH over 5 years

3) HAC's / AHRQ's -- $25 million over 5 years

*Minimums since private insurers will add their own programs

Value-Based Purchasing

- CMS calculates a VBP incentive payment percentage for each hospital based on its total performance score.
- A hospital's adjustment factor can be positive, negative or no change to the payment rate that would apply absent the VBP program.
- Zero-sum game to CMS (at least $1 billion will change hands).

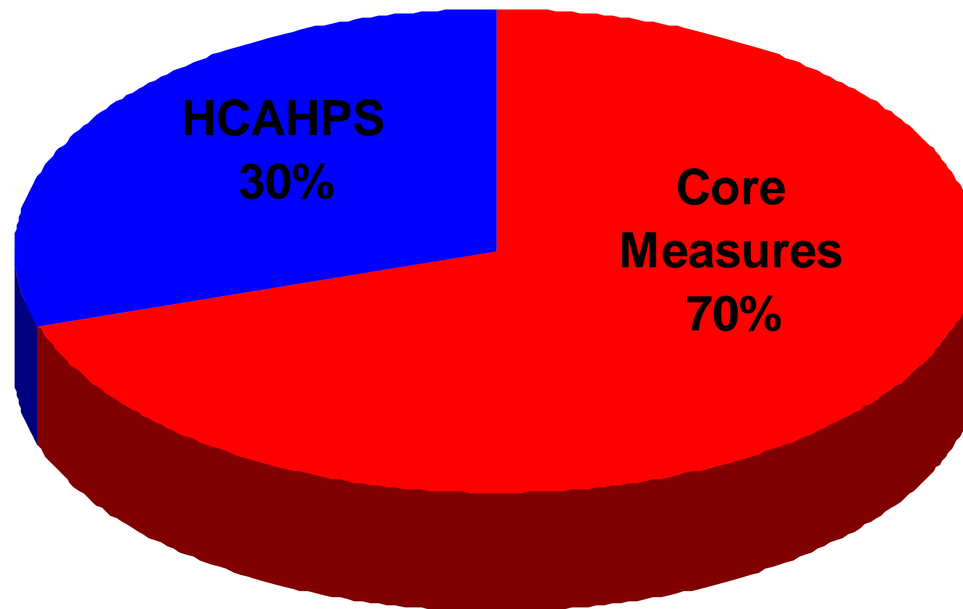
Amount Available Each Year Controlled by Statute

2013	1.00% of base-operating DRG payments
2014	1.25%
2015	1.50%
2016	1.75%
2017	2.00%

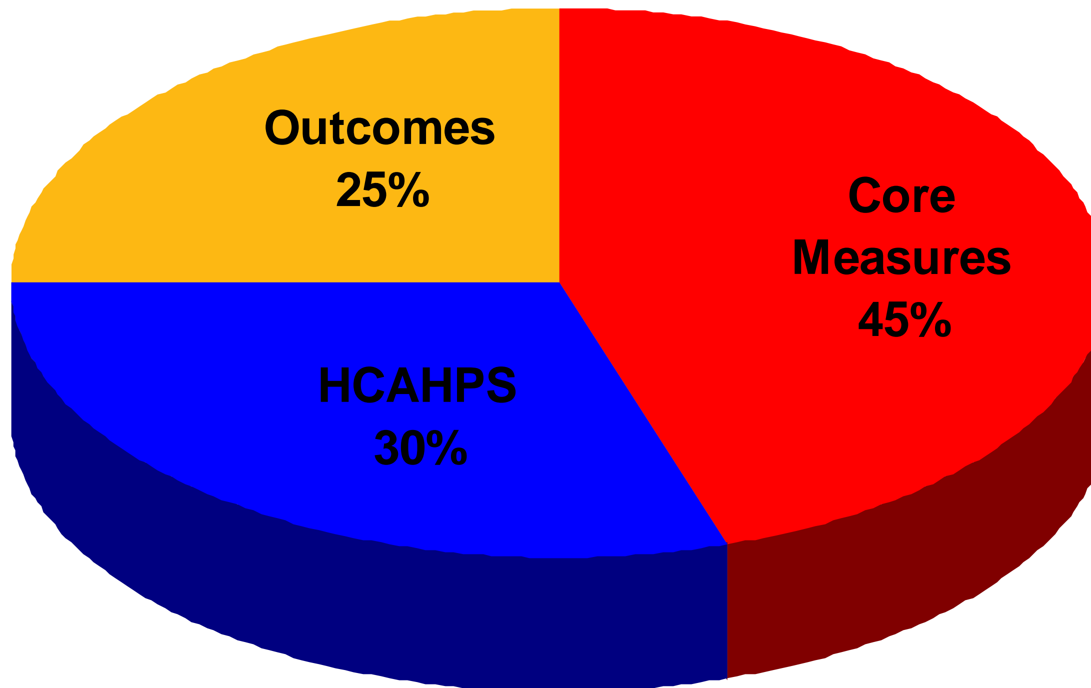
Value-Based Purchasing has a Fluid Scope:

- Measures change each year
- Weighting changes each year
- Dollars available change each year

Domain Weighting for FY 2013

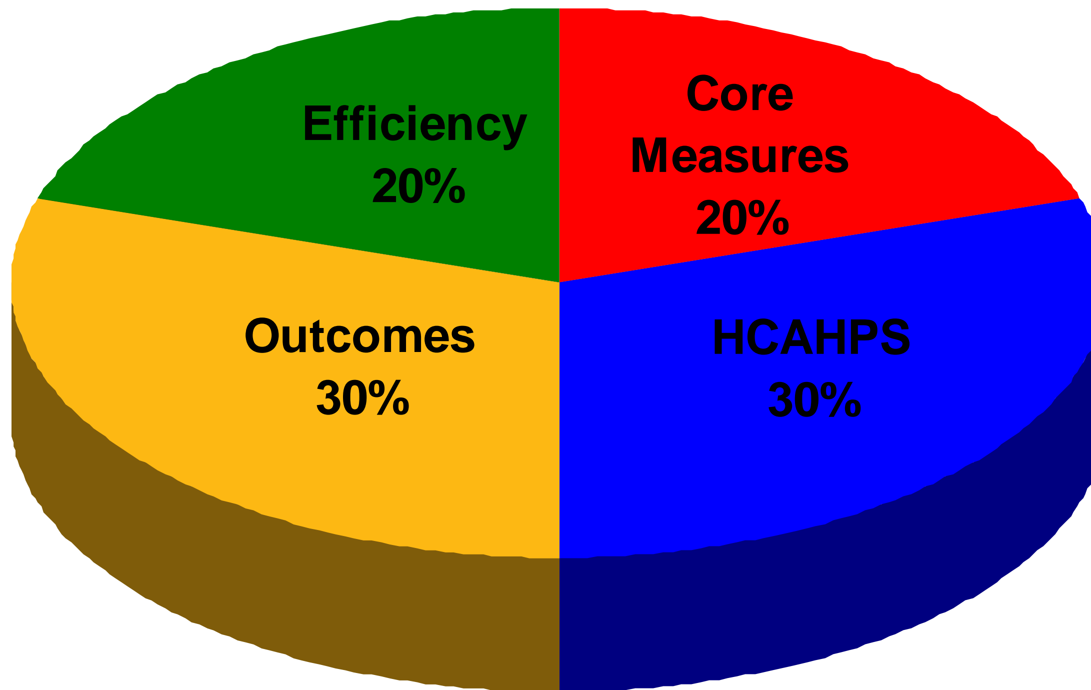


Domain Weighting for FY 2014



Amount at-risk rises to 1.25% of base DRG payment

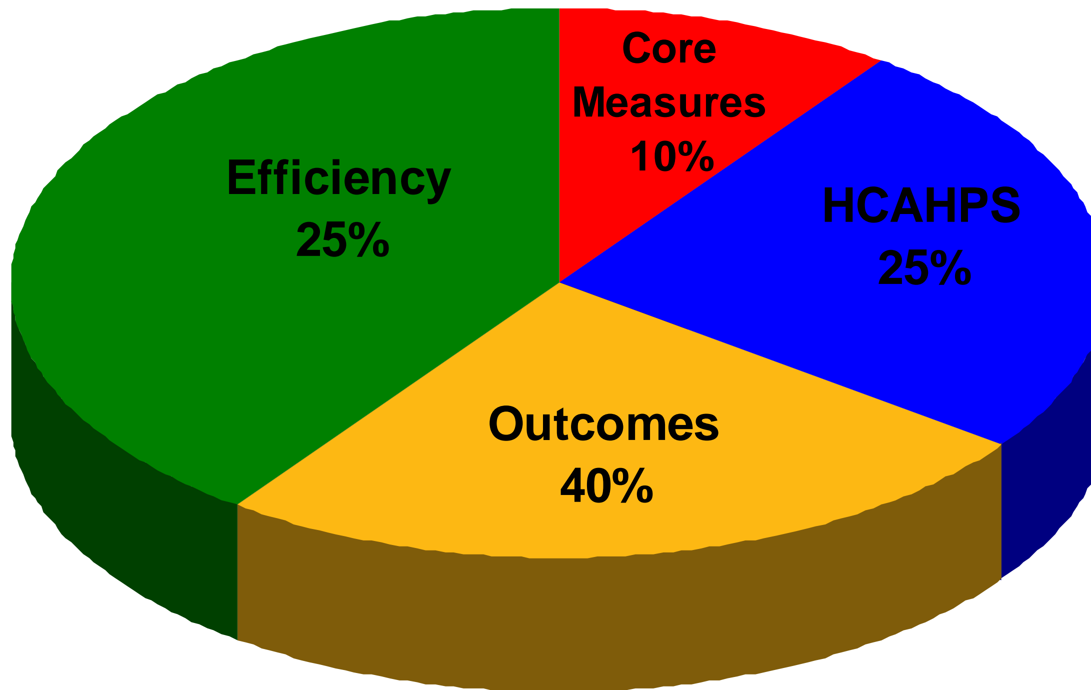
Domain Weighting for FY 2015



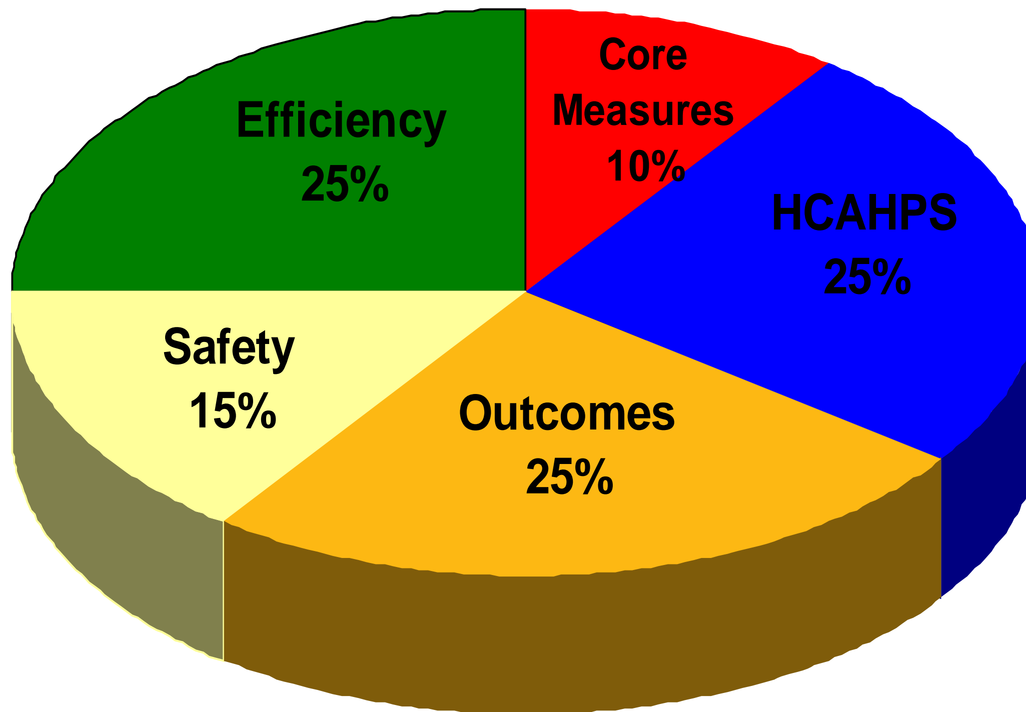
Amount at-risk rises to 1.50% of base DRG payment

Domain Weighting for FY 2016

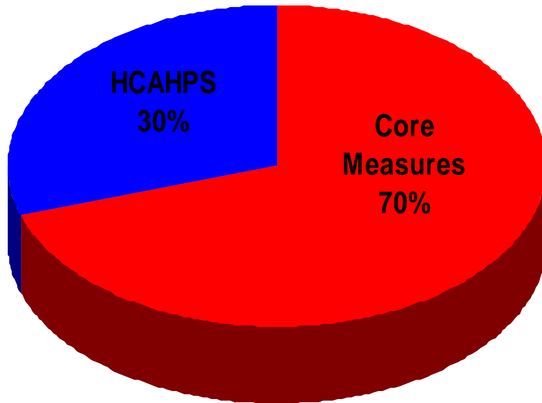
Overall VBP Score

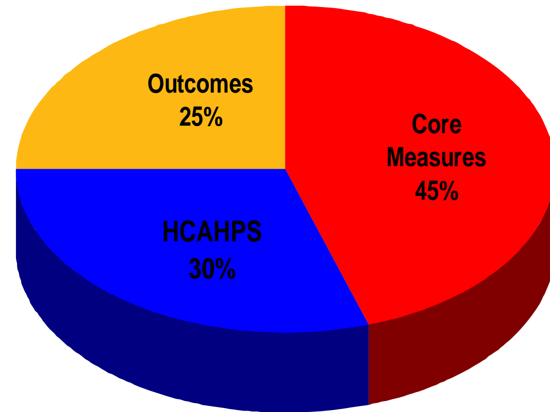


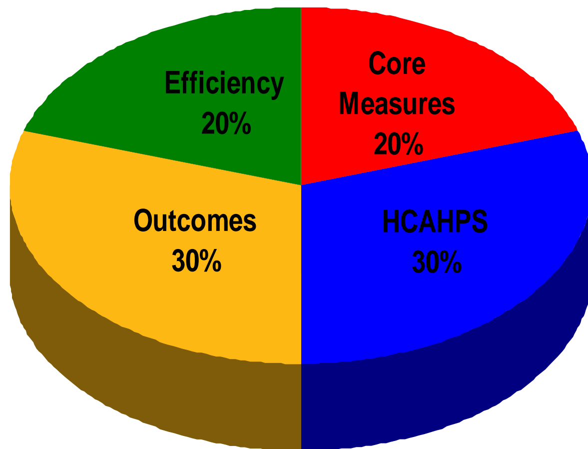
Domain Weighting for FY 2017

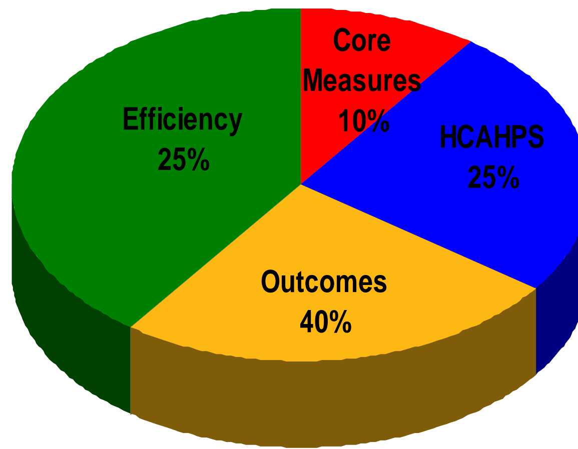


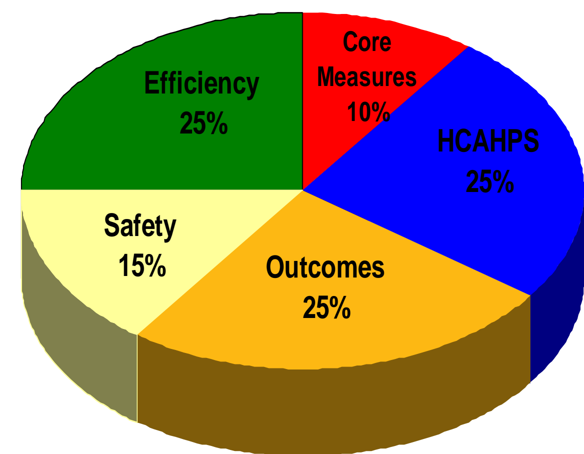
Value Based Purchasing











HAC Reduction Program:

- ACA requires it by FY 2015
- HAC's already addressed in VBP and adjustments to MS-DRG payment when preventable HAC's are present as secondary diagnosis.
- Those affected (applicable hospitals) will receive a 1% payment reduction.

Applicable Hospitals:

- A hospital that, relative to the national average, is in the top quartile of all included hospitals.
- Measured during the "applicable time period"—a two year time period.
- Payment adjustment is made after VBP and readmissions penalties are calculated.

Proposed Measures for the HAC Reduction Program

Measure Description	FY 2015	FY 2016	FY 2017
Domain 1: AHRQ Patient Safety Indicators			
Pressure Ulcer Rate	X	X	X
Foreign object left in body	X	X	X
Latrogenic pneumothorax rate	X	X	X
Postoperative physiologic and metabolic derangement rate	X	X	X
Postoperative PE/DVT rate	X	X	X
Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	X	X	X
Accidental puncture & laceration rate	X	X	X
Domain 2: CDC HAI Measures			
Central Line-associated Blood Stream Infection (CLABSI)	X	X	X
Catheter-associated Urinary Tract Infection	X	X	X
Surgical Site Infection (SSI): - SSI Following Colon Surgery - SSI Following Abdominal Hysterectomy		X	X
Methicillin-resistant Staphylococcus aureus (MRSA)			X
Clostridium difficile			X

IMPACT ANALYSIS:

- Trial for July 1, 2009 – June 30, 2011 was done.
- Large bed size, urban and teaching stand out as disproportionately represented in the top quartile.
- More than half of the teaching hospitals were in the top quartile.

READMISSION REDUCTION PROGRAM:

- Reduces payments if readmissions exceed an expected level.
- Based on formula that compares payments for actual readmissions to payments based on an estimate of expected readmissions.
- Both are risk-adjusted.
- Initially used AMI, HF, PN.

READMISSIONS:

- If ratio exceeds 1.0, every Medicare discharge is penalized.
- Penalties:
  - 1.00% in 2013
  - 2.00% in 2014
  - 3.00% in 2015 and beyond
- 2013 UH penalty - $550,000.

Medicare Spending per Beneficiary (MSPB)

As part of the Hospital VBP, the MSPB Measure assesses Medicare payments for services provided to a Medicare beneficiary during a spending per beneficiary episode.

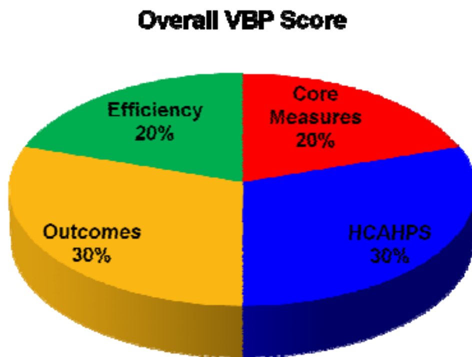
By measuring cost of care through this measure, CMS hopes to increase the transparency of care for consumers and recognize hospitals that are involved in the provision of high-quality care at a lower cost to Medicare.

Changes in Weighting

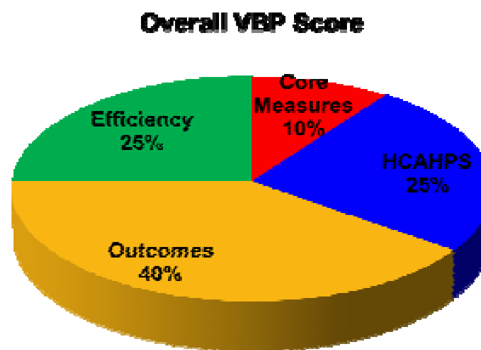
- Starting in FY 2015, Medicare Spending per Beneficiary becomes part of Value Based Purchasing (Efficiency)

- Initially 20% of score then increasing to 25% in 2016 and 2017

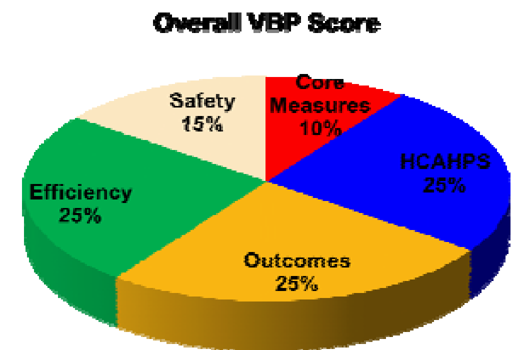
FY 2015



FY 2016



FY 2017



An MSPB Episode:

- All Part A and Part B claims
- 3 days prior to admission to 30 days post-discharge

Claim types in each of the 3 periods:

- Home Health Agency
- Hospice
- In-patient
- Out-patient
- Skilled Nursing Facility
- Durable Medical Equipment
- Carrier

Detailed MSPB Statistics*

	Your Hospital	State	U.S.
Number of Eligible Admissions	3,019.00	150,526.00	3,737,414.00
Average Spending per Episode	21,096.55	18,630.39	18,358.05
MSPB Amount (Avg. Risk-Adjusted Spending)	18,695.04	18,514.21	17,994.37
U.S. National Medial MSPB Amount	18,307.30	18,307.30	18,307.30
Average MSPB Measure	1.02	1.01	0.98

*This information will not be posted on *Hospital Compare.*

Prior to Admission (2% of Spending):

- 1% Out-patient
- 0.1% DME
- 0.8% Carrier

In-patient (57.2% of Spending):

- 0.2% DME
- 9.7% Carrier

Post-Hospital (40.7% of Spending):

- 3.2% Home Health
- 0.5% Hospice
- 13.2% In-patient
- 4.6% Out-patient
- 14% Skilled Nursing Facility
- 0.8% DME
- 4.3% Carrier

	UH CMC	State	Nation
Pre	2.0%	1.3%	1.4%
During	57.2%	53.6%	55.1%
Post	40.7%	45.0%	43.5%

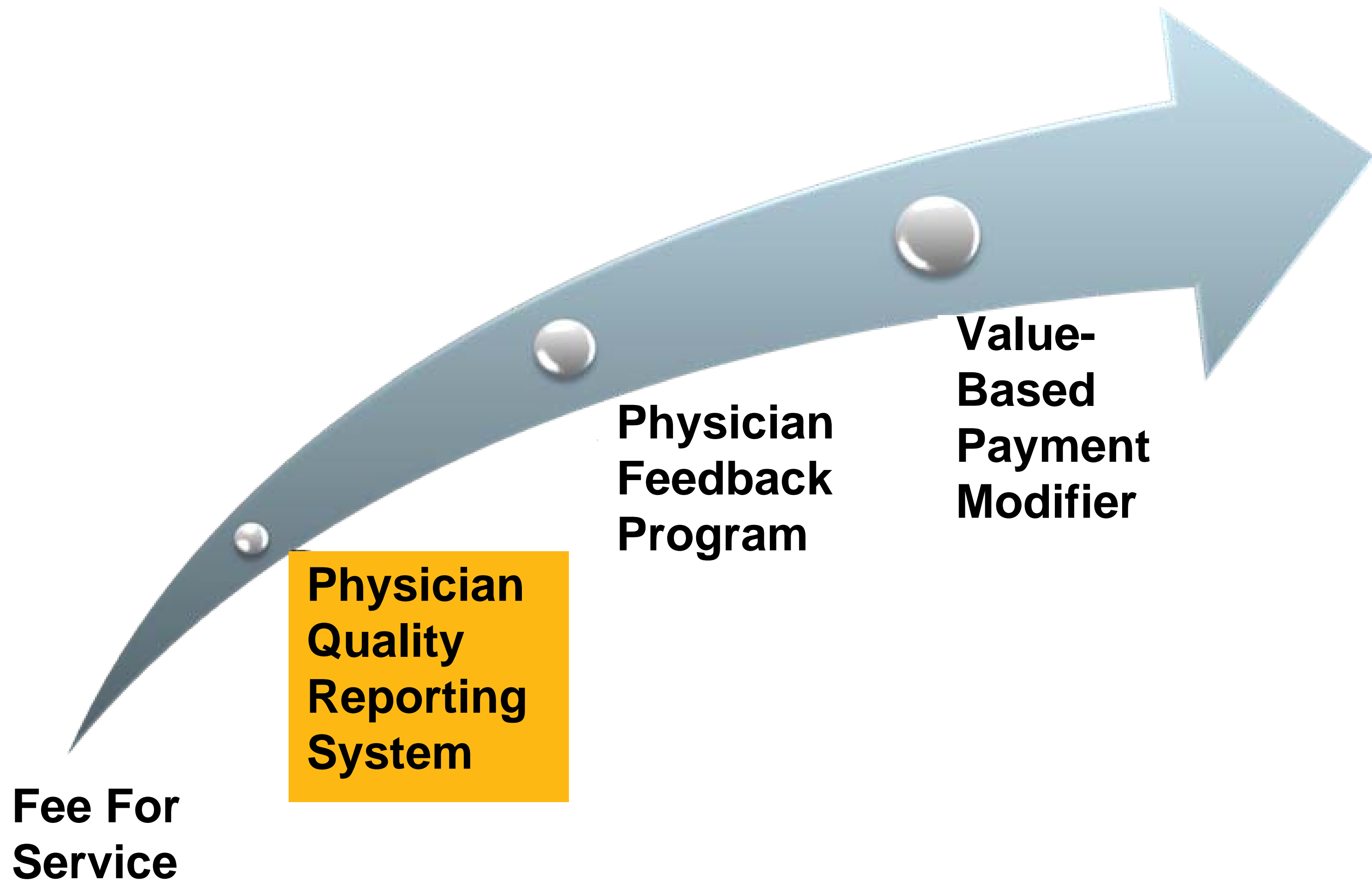
UH System Performance - 2012

	State	National	Case	Ahuja	Geauga	Regional	EMH	Parma	St John
Pre	1.4%	1.4%	1.8%	1.8%	1.4%	1.3%	1.2%	1.0%	1.6%
During	54.1%	55.6%	57.9%	51.4%	52.9%	44.8%	54.3%	47.5%	50.0%
Post	44.6%	43.0%	40.3%	46.8%	45.7%	53.9%	44.5%	51.5%	48.4%
Total Spend	$18,883	$18,704	$18,746	$18,673	$18,712	$20,031	$19,271	$20,824	$18,992

University Hospitals

Outpatient Reform

CMS Physician VBP Plan



PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

PQRS BASICS:

- Voluntary participation, pay for reporting
- Select performance measures
- Implementation and documentation of measures
- Performance reporting
- Bonus
- Feedback reports

PQRS Bonus Payment:

Percentage of Total Allowable Medicare Charges:

- 2011 = 1%
- 2012 = 0.5%
- 2013 = 0.5%
- 2014 = 0.5%
- 2015 = negative 1.5% payment adjustment
- 2016 = negative 2% payment adjustment

PQRS:

- There are now 259 measures available in 2013

- The minimum number of individual PQRS measures will go from 3 to 9

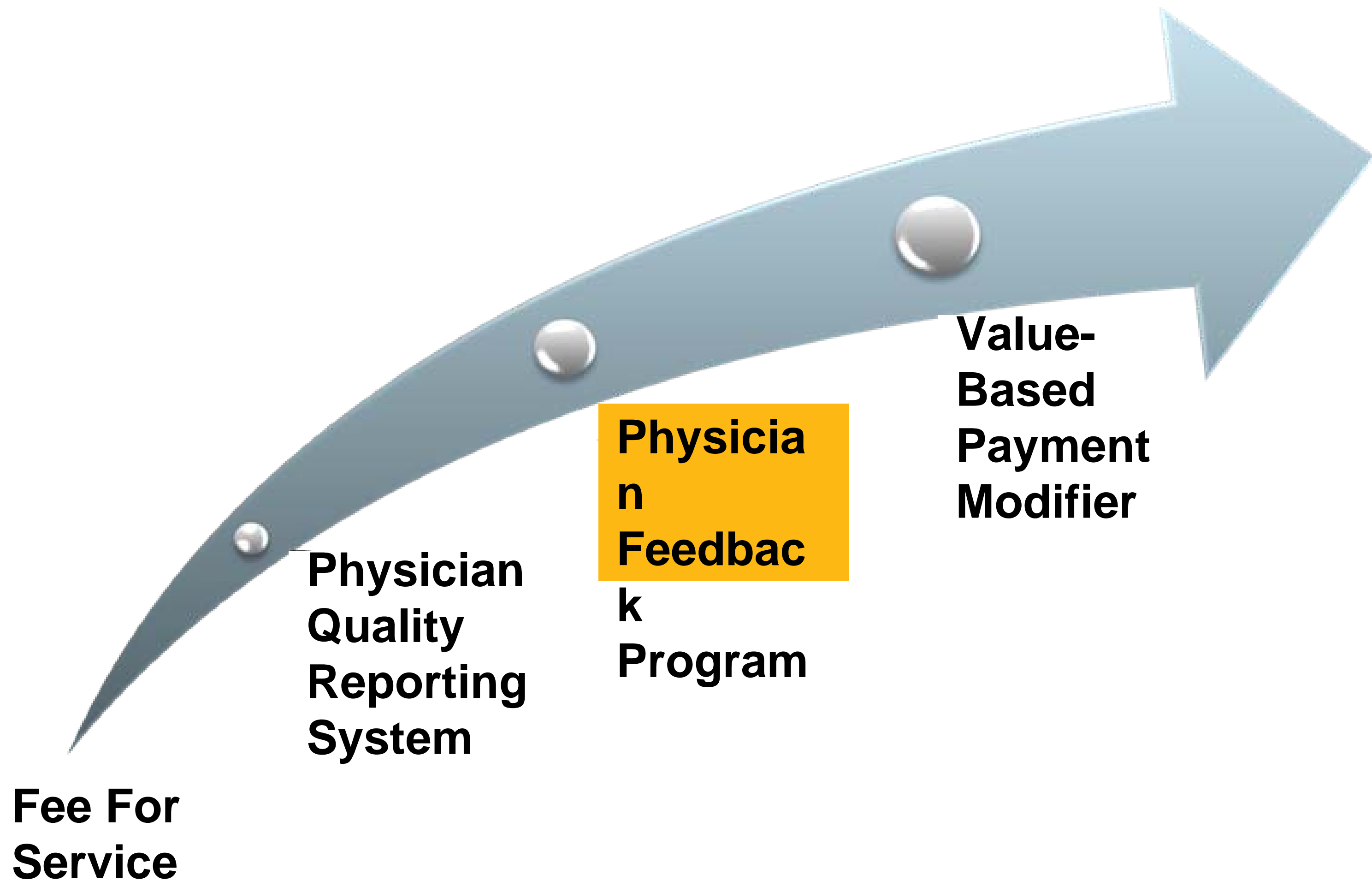
- Claims-based reporting will go away

Physician Compare Website:

ACA Section 10331, starting Jan. 1, 2013 – public reporting to include:

- PQRS results
- Patient health outcomes and functional status
- Assessment of continuity and coordination of care
- Efficiency measures
- Assessment of patient experience
- Assessment of safety, effectiveness and timeliness

CMS Physician VBP Plan



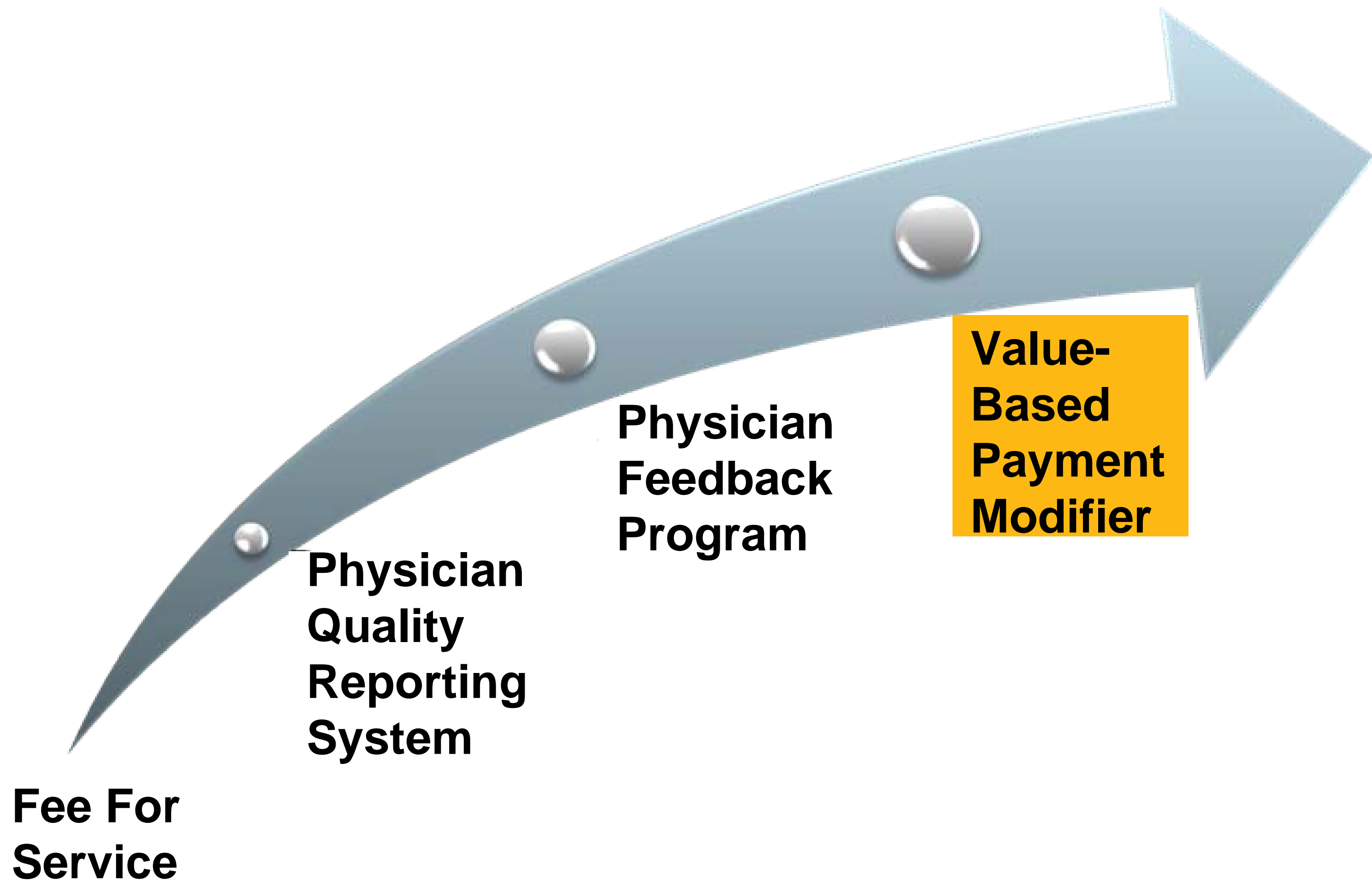
What are the Quality Resource Use Reports (QRUR's)?

QRUR's provide comparative information so that physicians can view the clinical care their patients receive in relation to the average care and costs of other physicians' Medicare patients.

The QRUR Accomplishes the following:

- Identifies areas where a physician is doing well and areas for improvement.
- Compares quality of care and cost with other MD's in area.
- Allows physicians to suggest what information should be added.
- Categorizes physicians' patients by degree of involvement (based on claims).

CMS Physician VBP Plan



Limitations of the Current Medicare Fee Schedule:

- No incentives to focus on relative cost or value of each service.
- No incentives to focus on cumulative cost of a physician's own services and services from other providers.
- No incentives to focus on the quality and outcomes of care furnished to beneficiaries.

Value-Based Payment Modifier:

- Budget-Neutral:
  - Payment will increase for some and decrease for others, but aggregate Medicare spending will not change.
- Calendar Year 2013 as initial performance period
- Jan. 1, 2015 – apply modifier to specific physicians
- Jan 1, 2017 – apply to all physicians

Goals of Value-Based Payment Mechanism

Improving Quality:

- Risk-adjusted outcome and patient experience measures
- Core set of measures appropriate to provider category
- Information collection with minimal burden
- Measures endorsed by multi-stakeholder organization

Goals of Value-Based Payment Mechanism

Lower Per-Capita Growth in Expenditures:

- Reward providers for reducing unnecessary expenditures
- Improve quality and reduce expenditures
- Apply cost-reducing and quality improving redesigned care processes to entire patient population.

Physician Branding:

- High Quality, Low Cost
- High Quality, High Cost
- Low Quality, Low Cost
- Low Quality, High Cost

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CONCLUSION

"Ultimately, however, what a physician does or does not do depends on the Hippocratic Oath, ethics and morals."

Robert H. Brook, MD, RAND Corporation

Is it working?

New HHS Data:

- Prevented 15,000 deaths in hospitals
- Avoided 560,000 patient injuries
- Saved $4 Billion