North Carolina Association for Healthcare Quality

HEALTHCARE PROFESSIONALS DEDICATED TO DELIVERING THE BEST OF CARE

Health Reform: What do I do now?

April 12, 2012

The Premier Healthcare Alliance

Transforming Healthcare Together®

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Premier essentials

The performance improvement alliance

- Uniting more than 2,500 hospitals and nearly 81,000 alternate sites of care
- $36 billion in annual group purchasing volume
- Nation's largest clinical/operational/supply chain comparative databases
- "Gold standard" code of conduct
- 2006 recipient of Malcolm Baldrige National Quality Award;
- Ethisphere's Most Ethical Companies five time award winner
- Award winning programs addressing environmentally sustainable sourcing

Cost Reduction
Group Purchasing & Supply Chain Improvement, Labor Management

Quality Improvement
Quality Measurement & Benchmarking, Safety Surveillance, Premier Research Services

Risk Mitigation
Liability, Benefits & Risk Management

Public Affairs
Shaping policy and advocating for members

Execution Engine
Comprehensive, accelerated approach to improving financial, operational and clinical performance.

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Political Landscape

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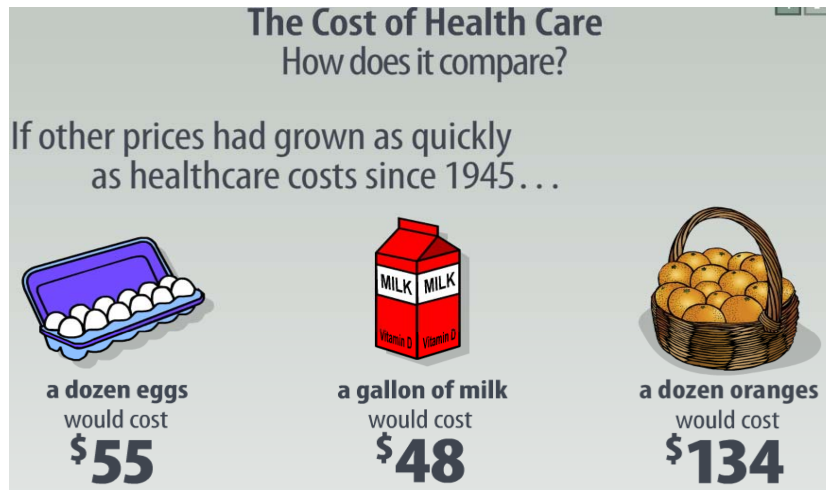
The cost of healthcare



Source: Institute of Medicine

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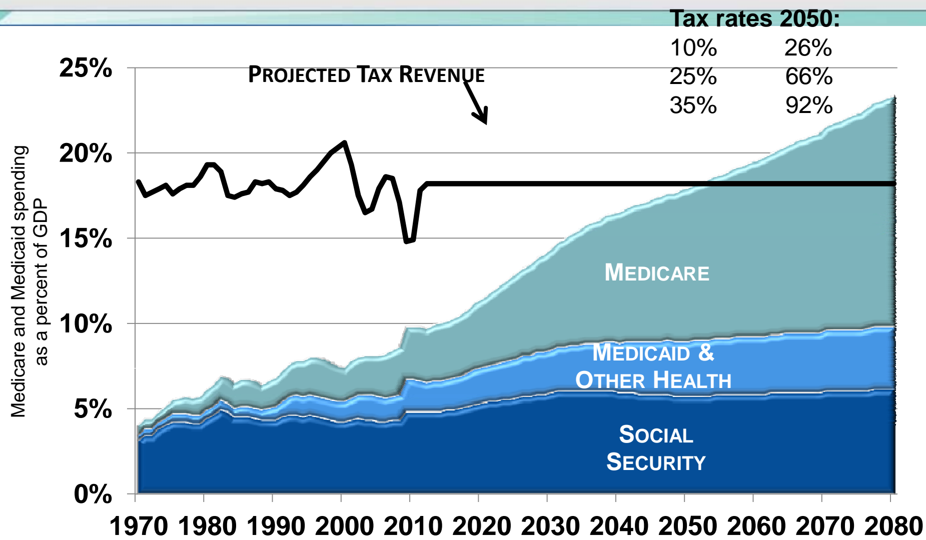
Healthcare spending and tax policy incompatible



Source: CBO

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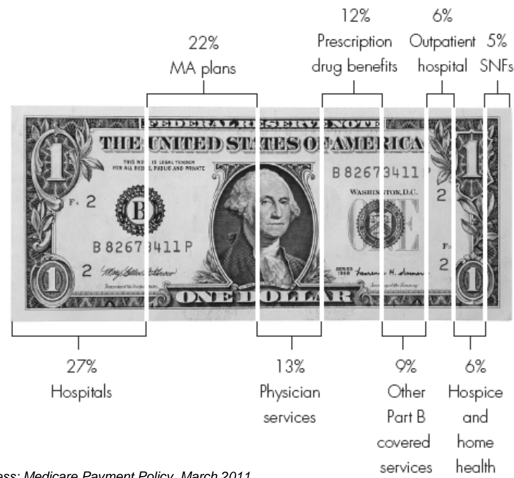
Medicare's biggest target
Hospitals represent over 27% of expenditures

Uses of funds for Medicare expenditures



MedPAC Report to the Congress: Medicare Payment Policy, March 2011

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The cost of healthcare: How much is waste?

Source: Institute of Medicine

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Five Questions the Supreme Court Will Review

- **Anti-Injunction Act – 1 ½ hours**
  - 11-398: "Whether the suit brought by respondents to challenge the minimum coverage provision of the PPACA is barred by the Ant-Injunction Act."
- **Severability – 1 ½ hours**
  - 11-393: "Whether the ACA must be invalidated in its entirety because it is nonseverable from the individual mandate that exceeds Congress' limited and enumerated powers under the Constitution."
  - 11-400: "Does the Affordable Care Act's mandate that virtually every individual obtain health insurance exceed Congress' enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act?"
- **Minimum Coverage Provision – 2 hours**
  - 11-398: "Whether Congress had the power under Article i of the Constitution to enact the minimum coverage provision."
- **Medicaid Expansion – 1 hour**
  - 11-400: "Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in South Dakota v. Dole, 483 U.S. 203 (1987), no longer apply?"

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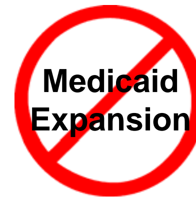
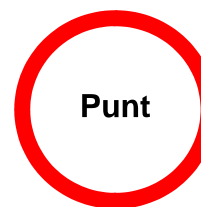
Supreme Court: Six possible outcomes by June

Uphold Entire Law

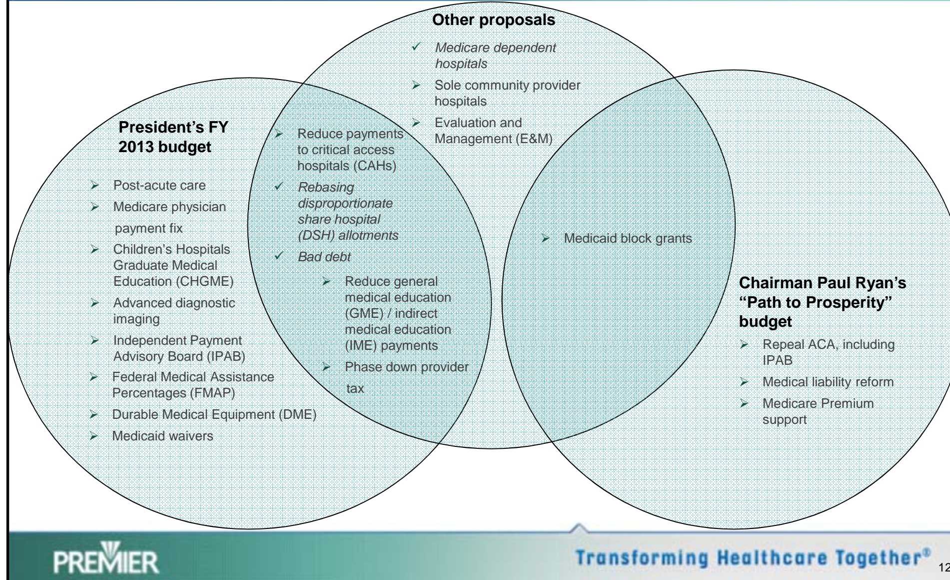




Current Climate in Washington, DC

- We aren't out of the woods yet; more cuts coming.
- 2012 deficit $1.08T; 7% of GDP
- Passed stop-gap with payroll tax holiday including modest hospital cuts, but physician patch at 0% through 12/31/12
  - Bad debt reduction from 75% to 65% ($6.9B)
  - Medicaid DSH rebasing in FY 2021 (saves $4B)
- Won't revisit healthcare until "lame duck" session
  - Will rely on CR
  - Must deal with extenders including physician fix
- Expect more cuts in 2013
- All healthcare providers are vulnerable

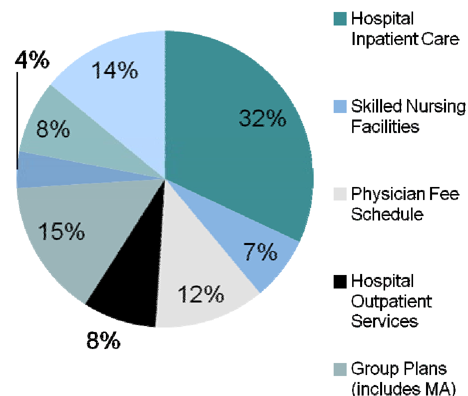
Proposed cuts to providers



$123B Medicare "sequestration" hits providers most

- "Super Committee" failure triggers across the board cuts of $1.2 trillion beginning Jan. 2013
- Medicare cuts are limited to 2% for all non-exempt Medicare programs and activities
  - Concentrated largely on providers and plan payments
- Programs exempt from cuts: Medicaid, CHIP, Part D, Catastrophic Coverage policies, and ACA exchange premium subsidies.
- 15% cut in exchange cost-sharing and related subsidies in addition to Medicare spending

Share of $123B FY13-FY21 Cuts, by Medicare Service Type[1]



2013 Debate: The evolution to capitation

Vestigial FFS	ACOs and bundled payment	Premium support
• Physician payments with Value-based modifier and volume growth cut • Hospital payments with enhanced pay-for-outcomes policies	• ACOs with capitated rates • Evolution through bundled payment • CMS remains the payer • Maintains current benefits and copay structure	• Defined contribution system • Run through exchanges • Minimum benefit plan • Competing private plans including Medicare • Must maintain actuarial equivalence with a benchmark plan

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Health Reform

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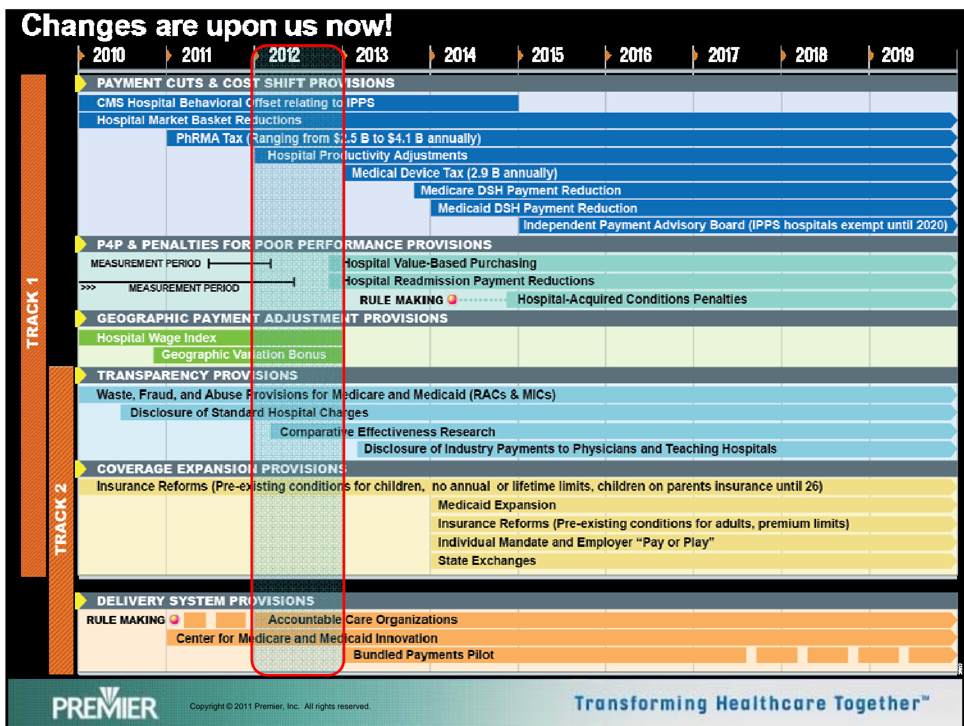
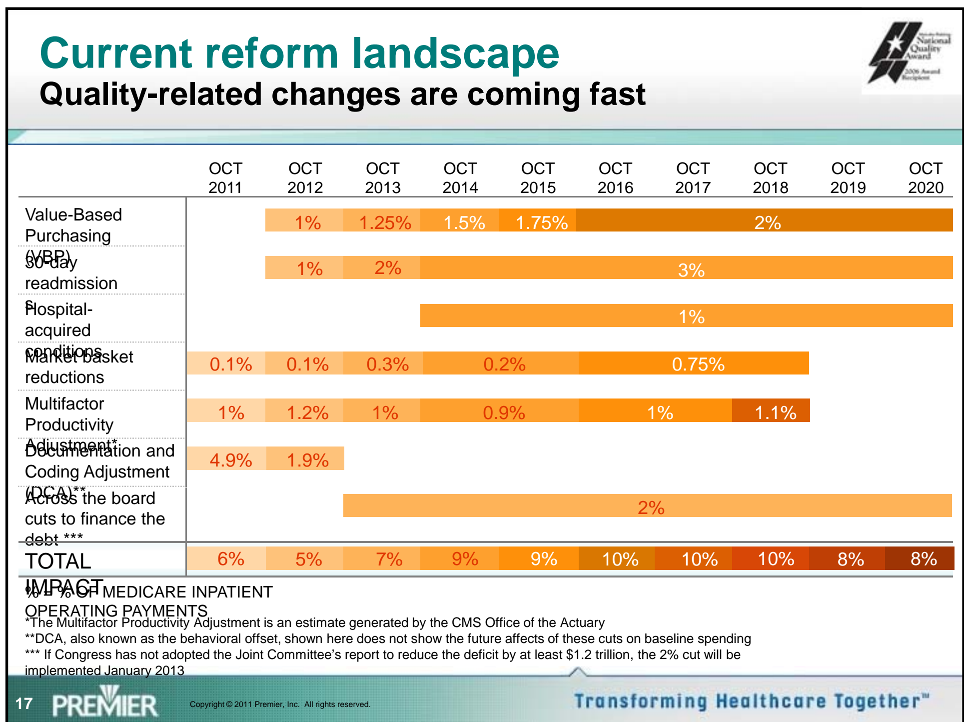
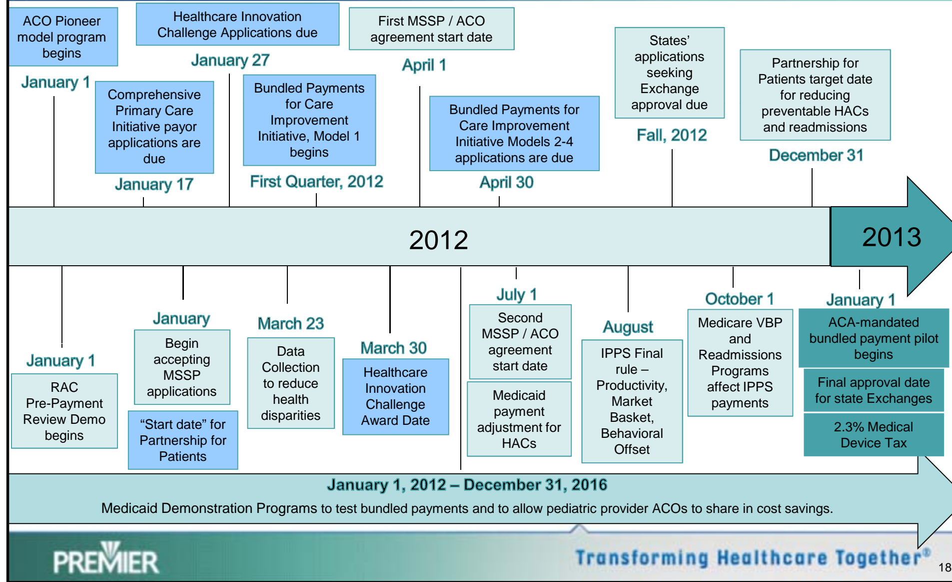




	OCT 2011	OCT 2012	OCT 2013	OCT 2014	OCT 2015	OCT 2016	OCT 2017	OCT 2018	OCT 2019	OCT 2020
Value-Based Purchasing (VBP)		1%	1.25%	1.5%	1.75%	2%				
30-day readmissions		1%	2%	3%						
Hospital-acquired conditions				1%						
Market basket reductions	0.1%	0.1%	0.3%	0.2%		0.75%				
Multifactor Productivity Adjustment*	1%	1.2%	1%	0.9%		1%		1.1%		
Documentation and Coding Adjustment (DCA)**	4.9%	1.9%								
Across the board cuts to finance the debt ***			2%							
TOTAL IMPACT % OF MEDICARE INPATIENT OPERATING PAYMENTS	6%	5%	7%	9%	9%	10%	10%	10%	8%	8%

*The Multifactor Productivity Adjustment is an estimate generated by the CMS Office of the Actuary
**DCA, also known as the behavioral offset, shown here does not show the future affects of these cuts on baseline spending
*** If Congress has not adopted the Joint Committee's report to reduce the deficit by at least $1.2 trillion, the 2% cut will be implemented January 2013



Exchanges

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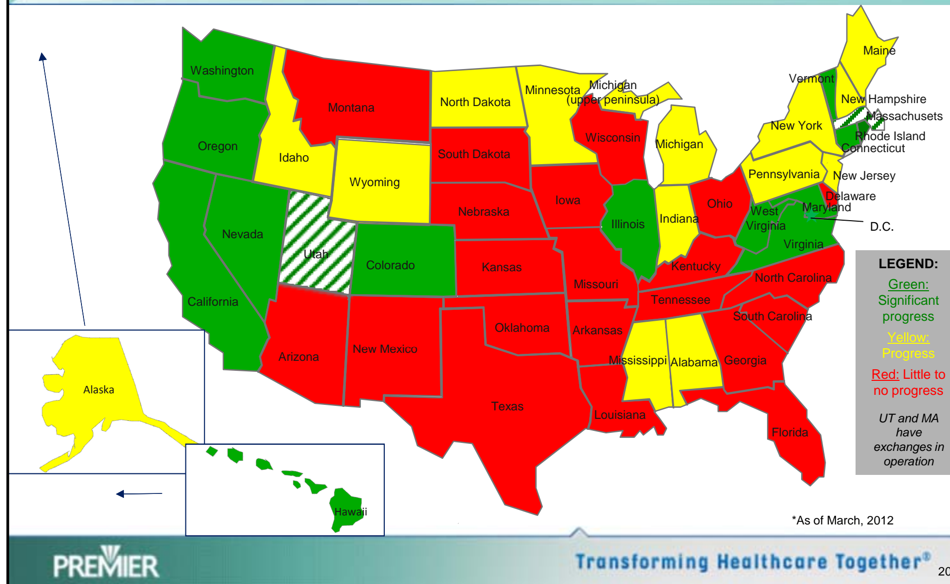
*Progress in establishing exchanges



*As of March, 2012

Exchange implications

- Estimated 22M will join exchanges by 2022 (CBO)
- Possible small employers will dump to exchanges
- Many individuals will purchase “Bronze” plan
  - Influence consumer behavior
  - Will drive “higher value” plans
  - Impact on potential for bad debt
- New competitive environment, transparency and marketing for insurers
- Exchanges create a marketplace mechanism; expandable to new populations
- With Medicaid expansion, 17M more insured by 2022 (CBO)

Payment

(ote –

Market basket / Productivity reductions

Inpatient & outpatient services

	MB	Prod
2010-11*	0.25%	n/a
2012	0.1%	1.4%
2013	0.1%	1.2%
2014	0.3%	1.1%
2015	0.2%	1.1%
2016	0.2%	1.2%
2017-19	0.75%	1.3%

**Begins April 1, 2010*

Productivity adjustment for inpatient/outpatient began in FY2012

$112 B total savings over 10 yrs.

Medicare DSH cuts begin in FY2014

- **$22.1 B** over 10 years
- 75% reduction in Medicare DSH payments
- Portion distributed back based on proportion of national uncompensated care

PLUS

Medicaid DSH cuts begin in FY2014

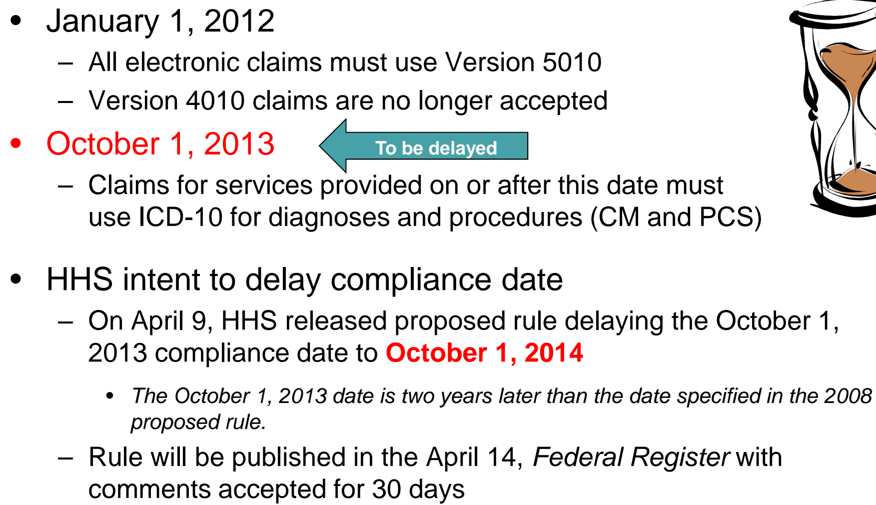
- **$14.0 B** over 10 years
- HHS to develop methodology for reducing federal DSH allotments to states

EQUALS

$36.1 B total in cuts over 10 yrs.

Total impact = $148B over 10 years

ICD-10 Compliance Timeline



- January 1, 2012
  - All electronic claims must use Version 5010
  - Version 4010 claims are no longer accepted
- October 1, 2013 ← To be delayed
  - Claims for services provided on or after this date must use ICD-10 for diagnoses and procedures (CM and PCS)

- HHS intent to delay compliance date
  - On April 9, HHS released proposed rule delaying the October 1, 2013 compliance date to **October 1, 2014**
    - *The October 1, 2013 date is two years later than the date specified in the 2008 proposed rule.*
  - Rule will be published in the April 14, *Federal Register* with comments accepted for 30 days

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Readmissions

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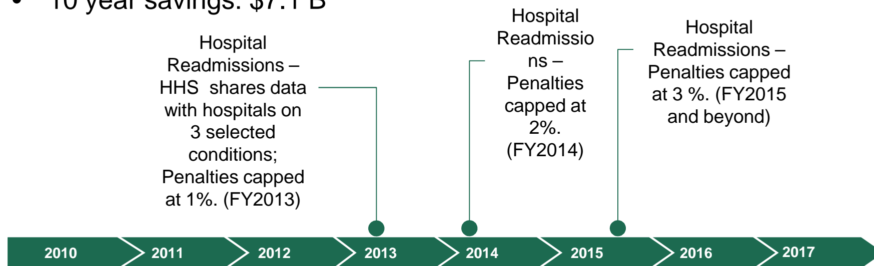
Readmissions

- Up to 1% cut to Medicare inpatient payments for "excess" readmissions in FY 2013, 2% in FY 2014, up to 3% in 2015 and beyond
- Initially AMI, CHF, PN in FY 2013
- 30-day, all-facility, all-cause risk adjusted measures on Hospital Compare (uses 3-years worth of data)
- Expands to COPD, CABG, PTCA, and other vascular in 2015
- 10 year savings: $7.1 B



Readmissions (FY 2013)

- FY 2012 final rule provides measure details
- FY 13 rule will include payment methodology and process
- CMS will use AMI, HF and PN 30-day Medicare Risk-standardized Readmission measures based on 3 years of data (July 1, 2008 through June 30, 2011)

Excess readmission rate = observed rate/expected rate – 1
Rate should be= observed-expected

- Penalty more than recoups the Medicare spending on excessive readmissions
- Does not alter the measures to remove cases such as planned readmissions
- Excludes hospitals with fewer than 25 cases in each area

Premier Economic Outlook:
Efficiency opportunities by category

QUALITY INDICATORS	
Cost of Patient Safety Indicators	$564,126
Excess Readmissions	$3,825,810
Overall Length of Stay	$2,625,343
ICU Length of Stay	$339,083

SUPPLY CHAIN INDICATORS	
Non-Automated Purchase Orders	$51,700
Intra-op CNS Drug Expense per OR Case	$68,089
Anti-infective Expense per Adjusted Discharge	$419,008

UTILIZATION INDICATORS	
Blood Utilization Cost per Case	$1,059,253
Percent of Patients Utilizing ICU	$595,222
Diagnostic Imaging Utilization Cost per Case	$1,522,095
Laboratory Testing Utilization Cost per Case	$2,234,983
Respiratory Therapy Utilization Cost per Case	$1,502,371

LABOR INDICATORS	
Skill Mix Dollar Variance	$2,380,957
Overtime as a Percentage of Total Paid Hours	$708,922
Labor Exp per CMI Adj Discharge (Wage Index Adjusted)	$6,179,006

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Inefficiency in quality indicators: Readmissions example

	July 2010-June 2011		
MS-DRG	Readmit Rate	Total Cost	Avg Cost per Case
Major Joint Replacement/Reattachment of Lower Ext w/o MCC	8.3%	$230,278,230	$17,026
Spinal Fusion except cervical w/o MCC	8.0%	$93,442,281	$34,685
Heart Failure & Shock w/CC	21.7%	$91,338,992	$7,612
Chronic Obstructive Pulmonary w/MCC	20.7%	$73,680,288	$9,440
Cardiovascular Procedure w/Drug-Eluding Stent w/o MCC	8.2%	$70,480,657	$15,252

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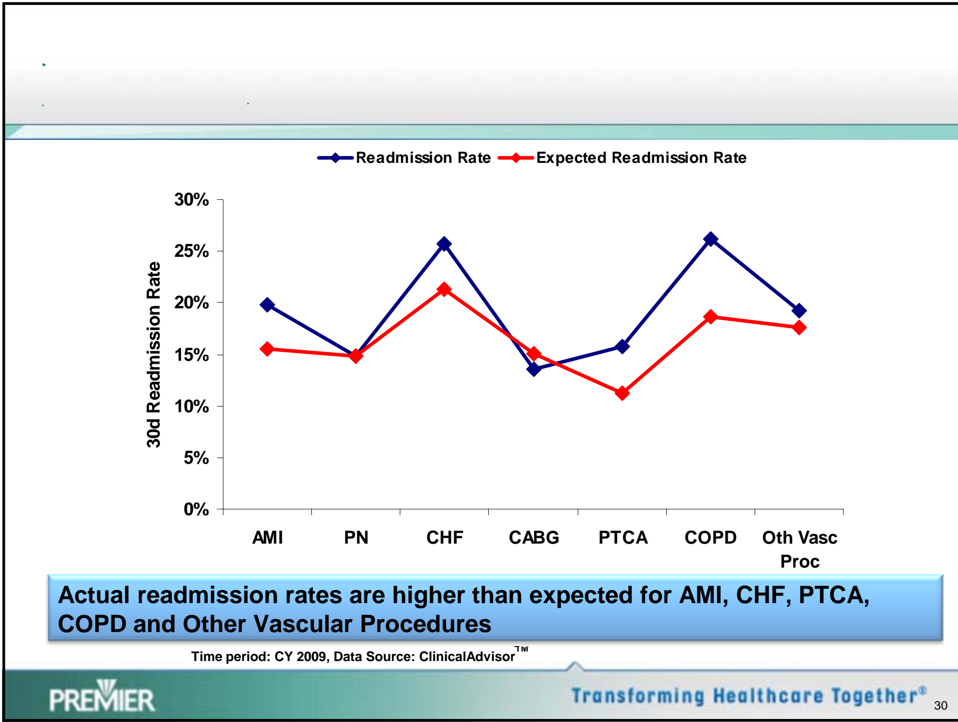

11013_Readmission Summary Analysis

REPORT FILTER:

3 Digit Principal Diagnosis		Readmitted Cases	Readmitted Patients	Arithmetic ALOS
428	HEART FAILURE*	145	114	6.16
250	DIABETES MELLITUS*	141	68	6.20
996	REPLACE & GRAFT COMPLIC*	115	101	8.37
038	SEPTICEMIA*	109	98	11.13
998	OTH SURGICAL COMPL NEC*	101	93	7.67
V58	ENCOUNTR PROC/AFTRCR NEC	95	52	5.17
276	FLUID/ELECTROLYTE DIS*	85	65	3.25
V56	DIALYSIS ENCOUNTER*	72	3	1.19
414	OTH CHR ISCHEMIC HRT DIS	57	54	2.70
584	ACUTE RENAL FAILURE*	56	54	7.48
427	CARDIAC DYSRHYTHMIAS*	48	43	5.29
486	PNEUMONIA, ORGANISM NOS	46	43	7.43
577	DISEASES OF PANCREAS*	46	28	6.98
518	OTHER LUNG DISEASES*	44	41	9.73
599	OTH URINARY TRACT DISOR*	42	40	4.29
403	HYPERTENSIVE RENAL DIS*	40	27	6.03
997	SURG COMPL-BODY SYST NEC	36	34	10.58
682	OTHER CELLULITIS/ABSCESS	35	33	5.51
008	INTESTINAL INFECTION NEC	32	23	9.19
571	CHR LIVER DIS/CIRRHOSIS*	30	25	6.73
578	GASTROINTESTINAL HEMORR*	30	30	4.73
491	CHRONIC BRONCHITIS*	29	27	5.79

Chronic diseases account for highest volume readmission diagnoses

Surgical complications account for 137 readmissions.

3 patients responsible for 72 readmissions. Significant impact on overall readmission rate.

Consider potential Harm or ADEs from previous admission, UTIs, ? C. Diff., anticoagulants? Fluid overload?

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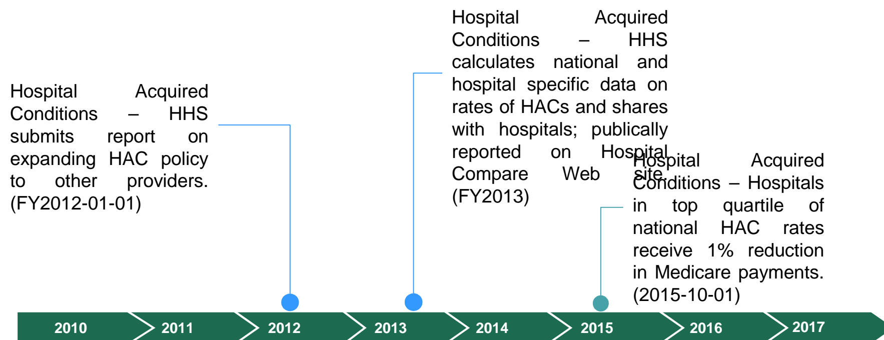
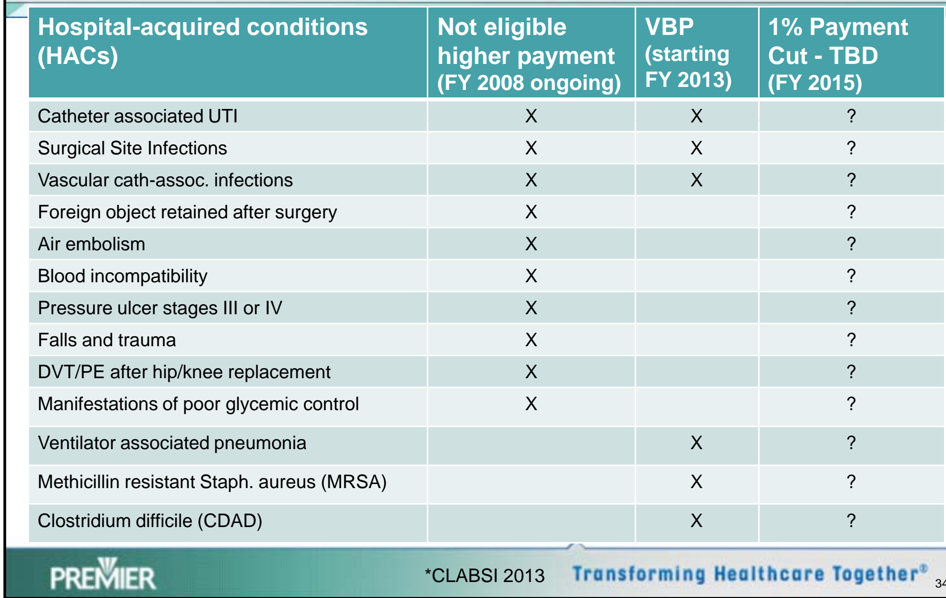
Hospital-Acquired Conditions

Hospital-acquired conditions

- Worst performing quartile of hospitals **penalized 1% of Medicare inpatient payments** beginning FY 2015 ($1.5 billion over 10 years)
- Public reporting of HAIs



Overlapping Medicare HAC policies



Hospital-acquired conditions (HACs)	Not eligible higher payment (FY 2008 ongoing)	VBP (starting FY 2013)	1% Payment Cut - TBD (FY 2015)
Catheter associated UTI	X	X	?
Surgical Site Infections	X	X	?
Vascular cath-assoc. infections	X	X	?
Foreign object retained after surgery	X		?
Air embolism	X		?
Blood incompatibility	X		?
Pressure ulcer stages III or IV	X		?
Falls and trauma	X		?
DVT/PE after hip/knee replacement	X		?
Manifestations of poor glycemic control	X		?
Ventilator associated pneumonia		X	?
Methicillin resistant Staph. aureus (MRSA)		X	?
Clostridium difficile (CDAD)		X	?

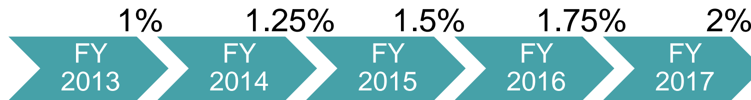
*CLABSI 2013

Value-Based Purchasing

Inpatient Value-Based Purchasing

- Three relevant rules in CY 2011
  - VBP Released April 29, published in May 6 *Federal Register*
  - IPPS rule August 1
  - OPPS rule November 1
- Budget neutral payment changes begin October 1, 2012 by reducing base operating payments for each discharge by

1% 1.25% 1.5% 1.75% 2%



- Rewards for achievement or improvement
- Quality measures from Hospital Compare measure set
  - 20 measures (12 process/8 HCAHPS dimensions) in FY 13, and
  - Adds 3 outcome measures (3 mortality) in FY 14

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2013 Measures and timeline
20 measures

12 Clinical Process measures

1. AMI
2. HF
3. PN
4. SCIP (SCIP 1,2,3 and 4 considered HAI)

8 Patient Experience measures (HCAHPS)

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Overall Rating of Hospital

Clinical Process and Patient Survey Timeline

- Baseline July 1, 2009 to March 31, 2010
- Performance July 1, 2011 to March 31, 2012

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FFY 2014 Domain Weighting & Standards Timeline

Domain	Weight	Baseline Period	Performance Period
Clinical Process	45%	April 1, 2010 - December 31, 2010	April 1, 2012 - December 31, 2012
Patient Experience	30%	April 1, 2010 - December 31, 2010	April 1, 2012 - December 31, 2012
Efficiency (Suspended)	0%	To be determined in future rule making	To be determined in future rule making
Outcomes • Mortality • HAC - Suspended • AHRQ - Suspended	25%	 • July 1, 2009 – June 30, 2010 • To be determined in future rule making • To be determined in future rule making	 • July 1, 2011 – June 30, 2012 • To be determined in future rule making • To be determined in future rule making

FY 2014 VBP Suspended Measures

- 8 Hospital-Acquired Conditions
  - Foreign Object Retained After Surgery
  - Air Embolism
  - Blood Incompatibility
  - Pressure Ulcer Stages III and IV
  - Falls and Trauma
  - Catheter-Associated Urinary Tract Infection (UTI)
  - Vascular Catheter-Associated Infections
  - Manifestations of poor glycemic control.
- AHRQ Patient Safety and Inpatient Quality Indicators
  - Complication/patient safety for selected indicators (composite)
  - Mortality for selected medical conditions (composite)

FY 2014 VBP Suspended Measures

- Medicare Spending per Beneficiary Measure for discharges between 3 days prior to inpatient admission through 30 days post-hospital discharge
- Calculating the ratio:

$$\frac{\text{Hospital's Medicare std. risk-adj. spending per beneficiary}}{\text{Median Medicare spending per beneficiary amount across all hospitals}}$$

- Will NOT be included in VBP for FFY 2014, but expect inclusion in future years after notice and comment period
- Measure will be posted on Hospital Compare in April 2012 for Hospital IQR FFY 2014 program
- CMS preview period February 1, 2012- March 1, 2012 for performance period of May 15, 2010 - February 14, 2011

Performance Standards

- Process, Outcome & Patient Experience
  - achievement standards
    - Threshold at median hospital performance during baseline
    - Benchmark at mean of top decile during baseline
  - improvement standards
    - Threshold is hospitals improvement baseline score
    - Benchmark at mean of top decile during baseline

Scoring

- The measure results are fed into formulae to convert to an achievement (0-10) or improvement score (0-9)
  - Measure result of 91% of applicable patients admitted for pneumonia were assessed and given the pneumococcal vaccination is entered into conversion formulae as 0.91
  - Choose improvement or achievement score (whichever higher)
- If measure results are below threshold, and the hospital did not improve, then score of 0
- In addition to achievement and improvement scores, also calculates an HCAHPS consistency score (0-20)
  - based on how well site is doing on all 8 dimensions
  - Calculation uses the lowest performing dimension
  - Worth 20 out of 100 total points

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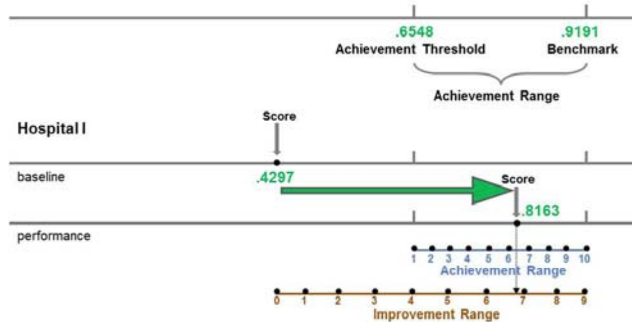
Process Improvement Example



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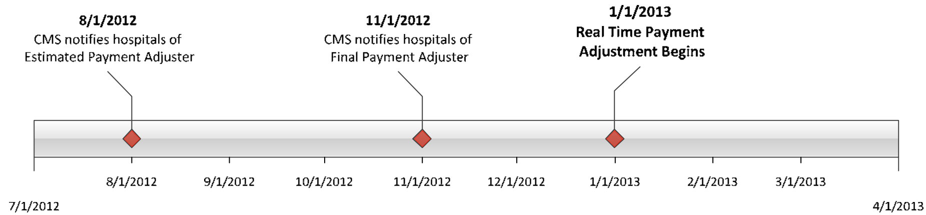
Payment

- Hospitals must be informed of VBP payment at least 60 days in advance of the payment year
- A payment adjuster will be applied to each claim that either increases or decreases each inpatient payment

VBP Payment Dates



VBP Simulated FY 2013 Impact – Overall Budget Neutral, QUEST out performs

	Hospital Count	Total Base Operating DRG Payments 2012 ($ millions)	1% Base Operating DRG Payments ($ millions)	CMS Net VBP Payment ($ millions)
All	3,054	86,513	865	0.0
Urban	2,280	77,206	772	(2.0)
Rural	774	9,307	93	2.0
Urban DSH	1,745	63,181	632	(17.5)
Major Teaching	243	17,990	180	(6.5)

Model uses Hospital Compare Data
- Baseline Period: January 1, 2009 to December 31, 2009
- Performance Period: January 1, 2010 to December 31, 2010

VBP Simulated FY 2014 Impact – Overall Budget Neutral, QUEST out performs

	Hospital Count	Total Base Operating DRG Payments 2012 ($ millions)	1.25% Base Operating DRG Payments ($ millions)	CMS Net VBP Payment ($ millions)
All	2,879	85,692	1,071	0.0
Urban	2,124	76,435	955	4.3
Rural	755	9,258	116	(4.3)
Urban DSH	1,713	63,071	788	(15.2)
Major Teaching	238	17,899	224	9.2

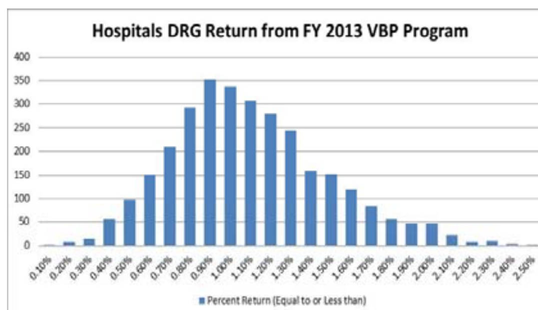
Model uses Hospital Compare Data
- Baseline Period: January 1, 2009 to December 31, 2009
- Performance Period: January 1, 2010 to December 31, 2010

VBP Hospital Returns FY 2013

Baseline 1/1/2009-12/31/2010 and Performance Period 1/1/2010-12/31/2010

- Top Performing Hospital earned 2.50% (1.50% net)
- Lowest Performing Hospital earned 0.06% (-0.94% net)
- Largest range is in top quartile (between 1.28% and 2.50% of total base operating DRG payments)

Quartile	Total DRG Percent
Top	2.50%
75th	1.28%
50th	1.00%
25th	0.78%
Bottom	0.06%

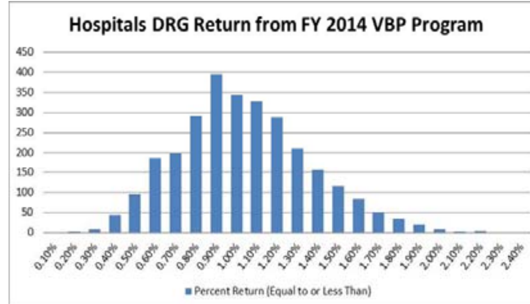


VBP Hospital Returns FY 2014

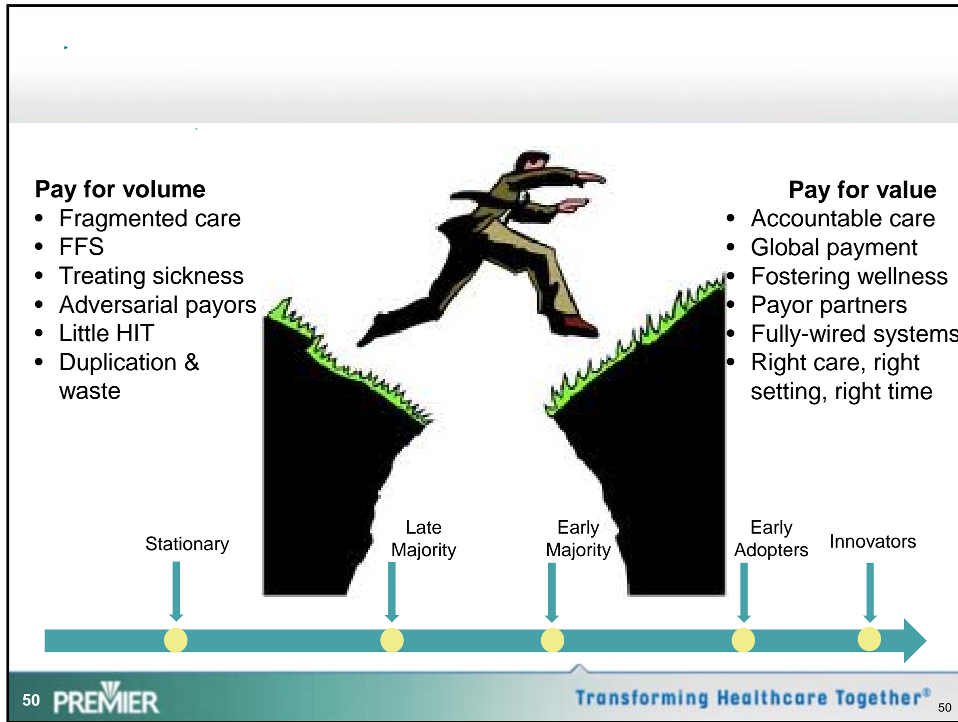
Baseline 1/1/2009-12/31/2010 and Performance Period 1/1/2010-12/31/2010

- Top Performing Hospital earned 2.32% (1.32% net)
- Lowest Performing Hospital earned 0.12% (-0.88% net)
- Largest range is in top quartile (between 1.18% and 2.32% of total base operating DRG payments)

Quartile	Total DRG Percent
Top	2.32%
75th	1.18%
50th	0.96%
25th	0.76%
Bottom	0.12%



ACOs



Pay for volume
Fragmented care
FFS
Treating sickness
Adversarial payors
Little HIT
Duplication & waste
Pay for value
Accountable care
Global payment
Fostering wellness
Payor partners
Fully-wired systems
Right care, right setting, right time
Stationary
Late Majority
Early Majority
Early Adopters
Innovators
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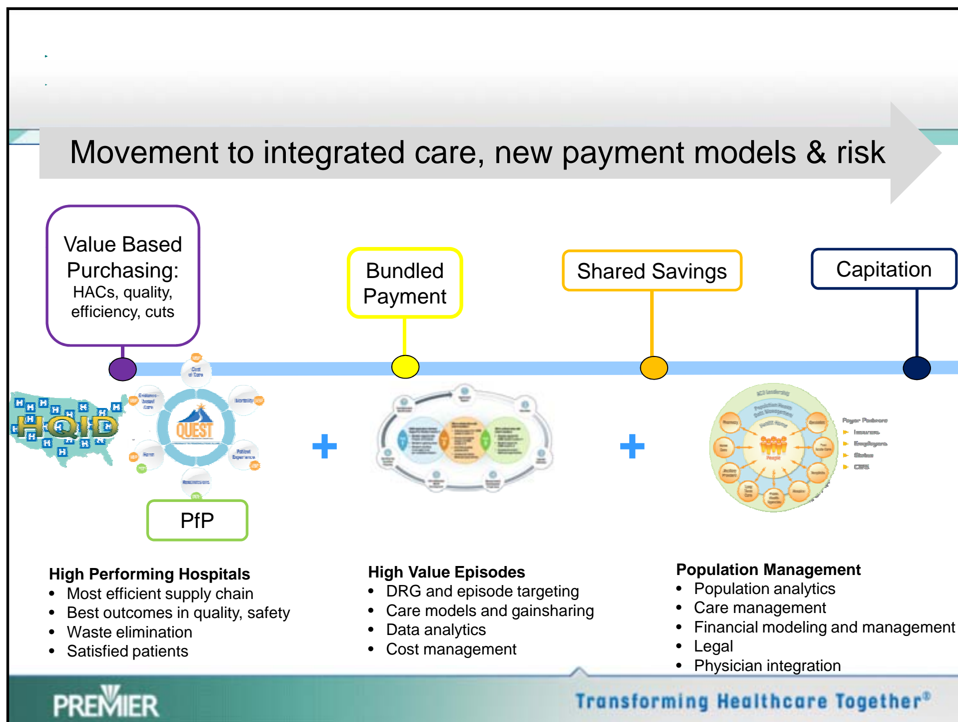

Movement to integrated care, new payment models & risk
Value Based Purchasing: HACs, quality, efficiency, cuts
Bundled Payment
Shared Savings
Capitation
HQID
QUEST
PfP
High Performing Hospitals
Most efficient supply chain
Best outcomes in quality, safety
Waste elimination
Satisfied patients
High Value Episodes
DRG and episode targeting
Care models and gainsharing
Data analytics
Cost management
Population Management
Population analytics
Care management
Financial modeling and management
Legal
Physician integration
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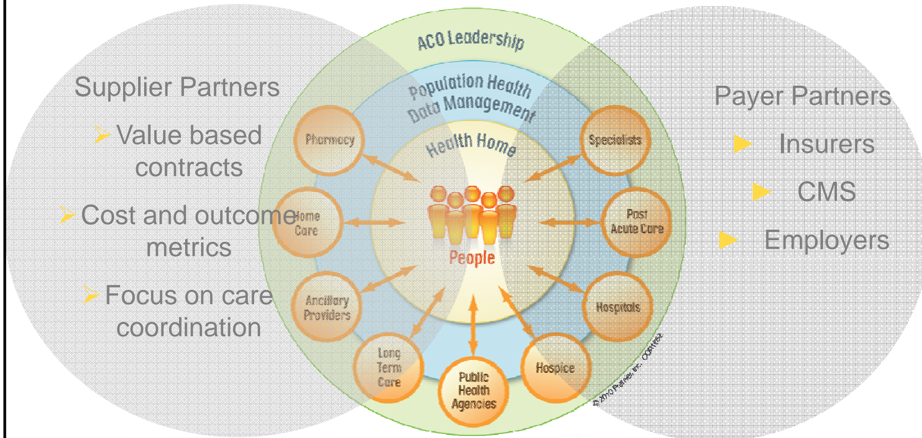
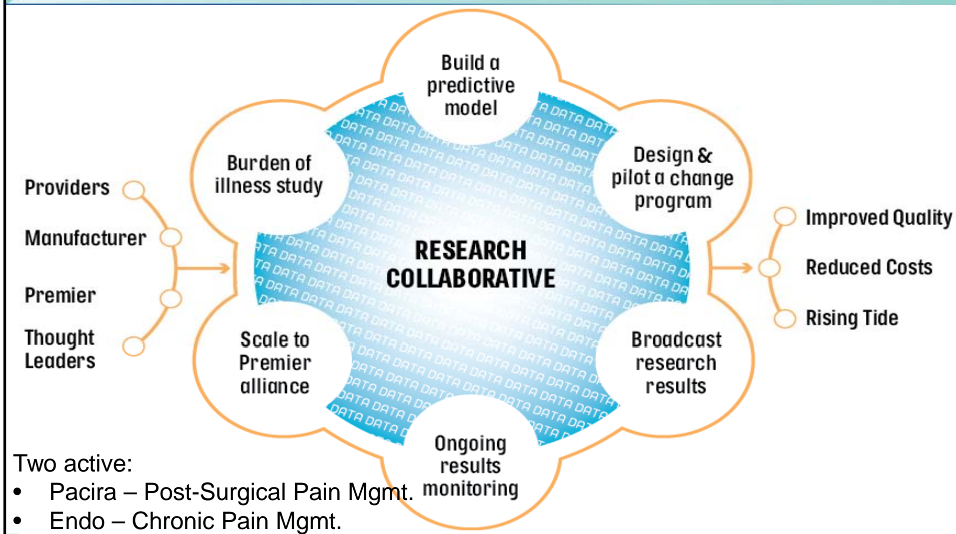
ACO model: Supplier Implications

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.



Linking Research to Real World Practice



Two active:
- Pacira – Post-Surgical Pain Mgmt.
- Endo – Chronic Pain Mgmt.

April 1 MSSP Participants

- 50 applications for April 1
- Many rolling to July 1 start with only 3 rejected
- 27 ACOs will participate as of April 1
- Mostly physician groups, but 10 Hospitals included
- 150 applications for July
- Rough geographic breakdown:
  - 30% Northeast
  - 30% Southeast
  - 20% Western
  - 8% Midwest
  - 8% South

"For anyone who doubted, today's numbers should give us tremendous confidence"
Acting Deputy Administrator Jonathan Blum

April 1 MSSP Participants

Accountable Care Coalition of Caldwell County, LLC
Lenoir, NC

Accountable Care Coalition of Coastal Georgia
Ormond, FL (Serving beneficiaries in GA and SC)

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New Bern, NC

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Premier ACO Physician Network
Lakewood, CA

Primary Partners, LLC*
Clermont, FL

RGV ACO Health Providers, LLC*
Donna, TX

West Florida ACO, LLC
Trinity, FL

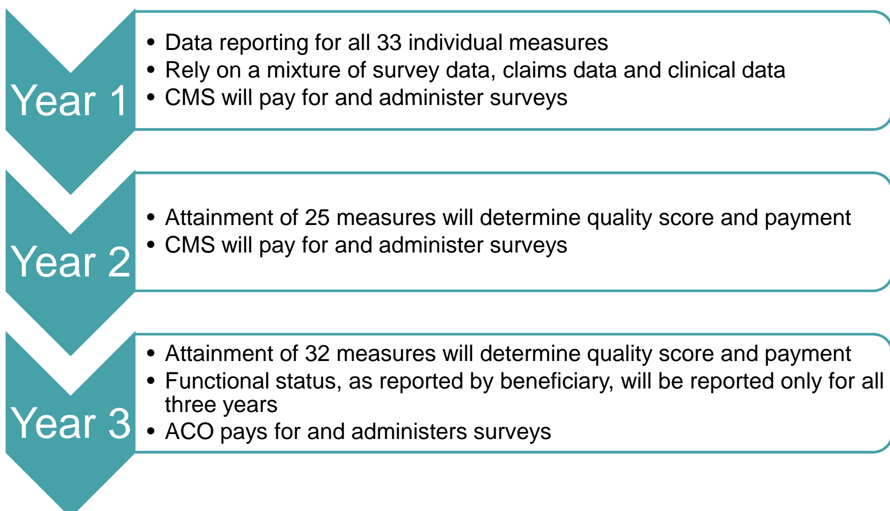
*Also received Advance payment model

Final MSSP rules

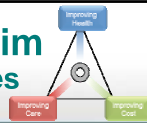
Key Provisions

- Beneficiaries can opt-out of data-sharing, but may need to seek care elsewhere if want to opt-out of the program entirely.
- Beneficiaries will be assigned to an ACO based on the plurality of the primary care services received from primary care physicians within an ACO.
  - If a beneficiary has not had a primary care service furnished by a PCP, assignment is based on a plurality of primary care services from physicians and non-physician practitioners within the ACO.
- 33 quality measures in four domains
  - Patient Experience
  - Care coordination and patient safety
  - Preventative health
  - Caring for at-risk populations
- Medicare Parts A, B and D data shared up to monthly.
- ACO must cover 5000 Medicare beneficiaries, and minimum savings rate (MSR) is based on the number of lives covered
- Two payment tracks
  - Track 1 is upside risk only (50% savings shared)
  - Track 2 is upside / downside risk all 3 years. (60% savings / losses shared)
- First dollar share on all savings after reaching the MSR
- ACOs are considered clinically integrated for antitrust.
- Five anti-trust and stark waivers offered
- No mandatory, upfront anti-trust review
- FQHCs and rural health clinics may now lead ACOs
- An April 1 and July 1 start date for 2012

Standards / Measures



Measuring the Triple Aim
CMS Final Rule – 33 Measures



Measure	Number	Owner	Data Submission Source
Preventive Health 8 Measures	5 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	CMS	GPRO Data Collection Tool
	2 Measures	AMA-PCPI	GPRO Data Collection Tool
At Risk Population 12 Measures	5 Measures	MN – Comm Measurement	GPRO Data Collection Tool
	2 Measures	CMS / AMA-PCPI	GPRO Data Collection Tool
	4 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI	GPRO Data Collection Tool
Patient/Care Giver Exp 7 Measures	6 Measures	AHRQ	Clinician Group CAHPS Survey
	1 Measure	AHRQ	Medicare Advantage CAHPs Survey
Care Coordination / Patient Safety 6 Measures	1 Measure	CMS	Claims
	1 Measure	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI/ NCQA	Survey or GPRO Data Collection Tool
	2 Measures	AHRQ ACSC	Claims
	1 Measure	CMS	GPRO Data Collection Tool / eRx Incentive Prog Reporting
Shared Savings			

Two tracks for Medicare ACOs

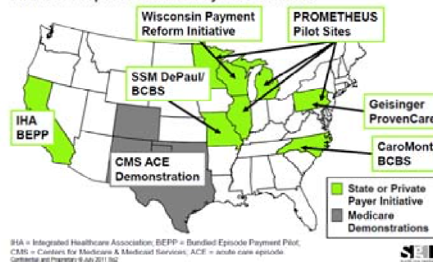
- One-sided (shared savings only) risk model
- Caps savings at 10% of benchmark
- Threshold of 2%-3.9% depending on size of population
- Once MSR met, share up to 50% of first dollar savings depending on quality scores

- Two-sided risk (shared savings and losses)
- Up to 60% shared savings
- First dollar savings/loss after 2% MSR surpassed
- Caps savings at 15% of benchmark
- Caps losses at 5% in year 1, 7.5% in year 2, and 10% in year 3

Bundled Payment

Bundled Payment Initiatives

- Quality improvement and reduced spending/increased margin:
- Medicare's Heart Bypass Center Demonstration - reduced mortality and saved 10% of expected spend ($42.3M) over 5 years.
- Geisinger's ProvenCare – 21% reduction in complications, 44% reduction in readmissions.
  - ProvenCare was able to reduce hospital costs by 5%.
- 12 NJ hospital program reduced 5.6% per admission over 18 months.
- 13 coronary stent gainsharing programs reduced costs by 7.4%.

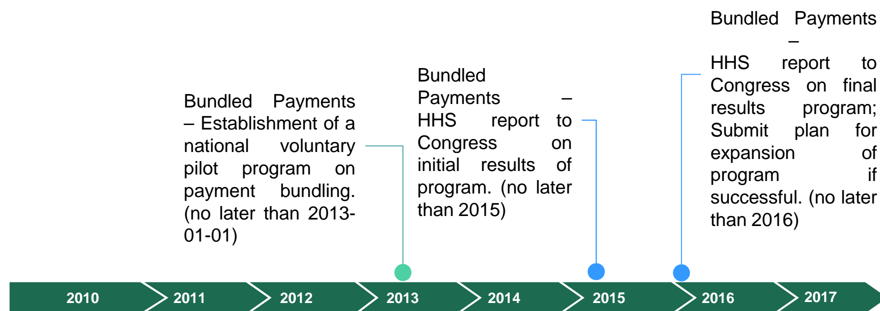


- Medicare Cataract Surgery Alternate Payment demonstration,
- Medicare Acute Care Episode (ACE) demonstration,
- Physician Hospital Collaboration demonstration, and
- 2005 Deficit Reduction Act (DRA) Medicare Gainsharing demonstration.

Source: Sg2

Bundled payments
Healthcare reform provision

- National voluntary pilot bundled payment in acute inpatient, physician services, outpatient, post-acute (no later than 2013)
- Episode of care: 3 days prior to admission and 30 days following patient discharge for 10 conditions
- Potential to expand pilot program, but remains voluntary



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CMS Initial Undertaking…More to Come

4 Models Now | **4 Models to Come** | **Future Models**

Table 1.

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

- ACA pilot by 2013
- Medicaid bundling demos?
- Private Sector Initiatives

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Conclusions

Payment reform across the care / payment silos

	Physician RBRVS	Outpatient Hospital and ASCs APC	Inpatient Acute Care MS-DRG	Long Term Acute Care MS-DRG	Inpatient Rehab RICs	Skilled Nursing Facility Care RUGs	Home Health Care HHRGs
VBP	VBP modifier plan published by 1/1/2012	VBP implementation plan submitted to Congress by 1/1/2011	VBP commences 10/1/2012	VBP test pilot by 1/1/2016	VBP test pilot by 1/1/2016	VBP implementation plan submitted to Congress by 10/1/2011	VBP implementation plan submitted to Congress by 10/1/2011
ACO	Accountable Care Organizations (spans all columns)						
Episode Pmts				PAC Episode Billing (Long Term Acute Care through Skilled Nursing Facility Care)			
		Acute Care Episode with PAC Bundling (Outpatient Hospital and ASCs through Home Health Care)					
		Acute Care Bundling (Outpatient Hospital and ASCs through Inpatient Acute Care)					
	Medical Home (Physician through Outpatient Hospital and ASCs)						

Partnership for Patients
Voluntary Pledge

- Announced April 12, 2011 —Government, Private Sector, Providers and Patients voluntarily pledging to improve care by 2013:
  - Reduce Readmissions by 20%-
    - Heart Failure,
    - Acute Myocardial Infarction, and
    - Pneumonia.
  - Reduce Hospital-acquired conditions by 40%-
    - Adverse Drug Events,
    - Catheter-Associated Urinary Tract Infections,
    - Injuries from Falls or Immobility,
    - Obstetrical Adverse Events,
    - Pressure Ulcers,
    - Surgical Site Infections,
    - Ventilator-Associated Pneumonia, and
    - Venous Thromboembolism.

Surviving Reform

- Unavoidable cuts require enhancing supply chain, productivity, and revenue cycle efforts
- Level of cut/reward within control of hospital for quality provisions
  - Create culture of transparency and leadership
  - Focus on evidenced-based care
  - Note payment based on *prior* performance
  - Benchmark against peers to gage impact
  - Rethink business case for services and technologies
- Consider advantages of delivery system reform options
- Coordination with physicians key on all fronts

Questions?

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VP, Policy Development & Analysis
Danielle_Lloyd@Premierinc.com

APPENDIX

10-month SGR/tax deal

- Relief provisions
  - Medicare SGR patch at 0% through 12/31/12
  - UI extension
  - Payroll tax extension
  - Medicare extenders
- Hospital and other healthcare pay-fors (10-year savings)
  - Medicare bad debt cut to 65% ($6.9B)
  - Medicaid DSH rebased in 2021 (saves $4B)
  - ACA Prevention and Public Health Fund cut by $5B
  - Medicare clinical lab fee schedule reduction of 2% ($2.7B)
  - Repeal of the Medicaid ACA provision specific to Louisiana ("Louisiana Purchase") ($2.5B)

Short Term?
Expiring Medicare Extenders

- Section 508 area wage index reclassifications **Extended thru March 31, 2012**
- Outpatient hold-harmless provision **Extended**
- Medicare Dependant Hospital (MDH) classification
- Low-volume hospital adjustment
- Rural ambulance add-on provision **Extended**
- Rural Medicare laboratory payments
- Technical component of physician pathology services **Extended**
- Medicare therapy caps exception process **Extended**
- Medicare physician work floor **Extended**

Deficit Reduction Commissions and Proposals

Proposal Authors	Date Released	Total Projected Savings
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici	November 17, 2010	$5.9 trillion over 9 years
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	December 1, 2010	$3.9 trillion over 9 years
Sens. Claire McCaskill (D-MO) and Bob Corker (R-TN)	February 1, 2011	Not Specified
Rep Paul Ryan (R-WI)	April 5, 2011	$5.8 trillion over 10 years
Budget Control Act of 2011	August 2, 2011	$1.2 trillion over 10 years
President Barack Obama's Plan for Economic Growth and Deficit Reduction	September 19, 2011	$3 trillion over 10 years (with $4 trillion with BCA cuts)
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)	Signed into law February 22, 2012	Increase direct spending by $11.7 billion over 10 years

Proposed Beneficiary Cuts

Proposal Authors	Raise Medicare Eligibility Age	Changes to Medicare Out-of-Pocket Cost-Sharing	Remove First Dollar Coverage from Medigap	Raise Medicare Part B Premiums	Income Means Testing	Establish combined annual deductible of $550 for A&B Medicare services, with 20% uniform co-insurance
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici		X		X	X	X (annual deductible of $560)
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	X	X	X			X
Rep Paul Ryan (R-WI)	X	X	X		X	
President Barack Obama's Plan for Economic Growth and Deficit Reduction		X	X	X	X	
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)						

Proposed Medicaid Cuts

Proposal Authors	Capping Medicaid Provider Taxes	Block granting of Medicaid	Cutting Medicaid DSH, increasing anti-fraud efforts, and possibly adjusting the ACA Medicaid Maintenance of Effort requirements allowing state more flexibility	Reduced Federal payments to states	Managed Medicaid for Dual Eligibles
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici					X
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	X		X (increase funding for CMS to fight fraud, waste and abuse)		X
Rep Paul Ryan (R-WI)		X			
President Barack Obama's Plan for Economic Growth and Deficit Reduction	X		X	X	
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)					

Proposed Hospital Cuts

Proposal Authors	Hospital bad debt and GME/IME	Special categories like CAHs, Medicare dependent and sole community provider hospitals	Put hospitals in IPAB	Rebase DSH payments in 2021
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici				
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	X		X	
Rep Paul Ryan (R-WI)			(Repeal IPAB)	
President Barack Obama's Plan for Economic Growth and Deficit Reduction	X	X		X
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)	X (Hospital bad debt)	X (Allowed Medicare Dependent Hospitals to expire – October 1, 2012)		X

Proposed Drugs Cuts

Proposal Authors	Mandatory Rebates / Price Controls	Expedite Introduction of Generic Drugs
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici	X	
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	X	
Rep Paul Ryan (R-WI)		
President Barack Obama's Plan for Economic Growth and Deficit Reduction	X	X
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)		

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Proposed Cuts to Other Providers

Proposal Authors	Cuts to home health, imaging, SNF, IRF, LTCH and post acute providers	Impose cost sharing for first 20 days of SNF stay	Require home health copayment
The Debt Reduction Task Force, chaired by Dr. Alice Rivlin and former Sen. Peter Domenici			
The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Sen. Alan Simpson	X (home health)		
Rep Paul Ryan (R-WI)			
President Barack Obama's Plan for Economic Growth and Deficit Reduction	X		X
CBO Options		X	X
Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630 / PL 112-096)			

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Short term?
Administration's FY 2013 budget

Medicare provider cuts (over 10 years)

- **Bad debt:** Phase down payments to 25% over 3 years for hospitals & SNFs ($35.9B)
- **IME:** Gradually reduce IME payments by 10% (9.7B)
- **CAHs:** Reduce CAH payments from 101% to 100% of reasonable costs and eliminate CAH designation for hospitals w/in 10 miles of another hospital ($2 B)
- **Post-acute care**
  - 1.1 percentage point reduction to IRF, LTCHs, SNFs, HHA ($56.7B)
  - Equalize IRF payments with SNF payments ($2B)
  - Reinstitute IRF 75% rule ($2.3B)
  - Up to 3% cut for SNFs with high readmission rates
- **Medicare physician payment fix:** Adjustment totaling $429B/10 yrs, but no specific policy
- **CHGME:** Cuts $177 million in FY 2013
- **Advanced diagnostic imaging:** reduction for advanced imaging equipment to account for higher levels of utilization ($820M)
- **IPAB:** Expand IPAB by reducing its growth rate target from GDP per capita plus 1% to GDP plus 0.5% and provide additional enforcement tools

Short term?
Administration's FY 2013 budget

Medicaid cuts (over 10 years)

- **Provider tax:** Phase down cap of 6% in FY 2014, to 4.5% in FY 2015, 4% in FY 2016, and 3.5% in FY 2017 and beyond. ($21.8B)
- **DSH:** Rebase Medicaid DSH allotments in FY 2021($8.25B)
- **FMAP:** Apply a single blended matching rate to Medicaid and CHIP starting in 2017 ($17.9B)
- **DME:** Limit Medicaid DME reimbursement based on Medicare rates ($2.9B)
- **Medicaid Waivers:** Expand state flexibility to provide benchmark benefit packages. (No savings)

Value-Based Purchasing

2013 VBP Measures

- **AMI**
  - AMI-7a Fibrinolytic Therapy Received w/n 30 Min of Hospital Arrival
  - AMI-8a Primary PCI Received w/n 90 Min of Hospital Arrival
- **Heart Failure**
  - HF-1 Discharge Instructions
- **Pneumonia**
  - PN-3b Blood Cultures Performed in the ED Prior to Initial ABX Received in Hospital
  - PN-6 Initial Antibiotic Selection
- **Healthcare-associated infections**
  - SCIP-Inf-1 Prophylactic ABX Received w/n 1 Hr Prior to Surgical Incision
  - SCIP-Inf-2 Prophylactic ABX Selection for Surgical Patients
  - SCIP-Inf-3 Prophylactic ABX Discontinued w/n 24 Hrs After Surgery End Time
  - SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6AM Postop Serum Glucose
- **Surgeries**
  - SCIP-Card-2 Surgery Pts on a BB Prior to Arrival That Received a BB During the Perioperative Period
  - SCIP-VTE-1 Surgery Patients with Recommended VTE Prophylaxis Ordered
  - SCIP-VTE-2 Surgery Patients Who Received Appropriate VTE Prophylaxis w/n 24 Hrs Prior to Surgery to 24 Hrs After Surgery

2013 VBP Measures (cont'd)

Survey Measures—HCAHPS

- Nurse communication (% Always)
  - Nurse-Courtesy/Respect
  - Nurse-Listen
  - Nurse-Explain
- Doctor communication (% Always)
  - Doctor-Courtesy/Respect
  - Doctor-Listen
  - Doctor-Explain
- Responsiveness of hospital staff (% Always)
  - Bathroom Help
  - Call Button
- Pain management (% Always)
  - Pain Control
  - Help with Pain
- Communication about medications (% Always)
  - New Medicine-Reason
  - New Medicine-Side Effects
- Cleanliness and quietness (% Always)
  - Cleanliness
  - Quietness
- Discharge information (% Yes)
  - Discharge-Help
  - Discharge-Systems
- Overall Rating (% 9 or 10)

FY 2014 VBP Measures

- Process of Care domain add SCIP-Infection-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
  - Finalized in OPPS 2012 Final Rule
- Patient Experience domain no measure changes
- Add new *Outcome* domain with three measures
  - AMI 30-day
  - HF 30-day
  - PN 30-day

Medicare Spending per Beneficiary Measure (MSPB)

- Hospital's average MSPB Amount, sum of the standardized, risk-adjusted spending across all of the hospital's eligible episodes divided by the number of episodes for that hospital
- Denominator is the median MSPB Amount across all hospitals

MSPB Episode

- A discharge date falls between 3 days prior to inpatient admission through 30 days post-hospital discharge
- Index Admission includes only a discharge that occurs prior to the 30 days
  - There is only one index admission per episode
- Admissions NOT considered to be index admission
  - Admissions that occur within 30 days of discharge from another index admission
  - Acute-to-acute Transfers
  - Episodes where index admission claim has $0 payment
  - Admissions with discharge dates less than 30 days from end of performance period

MSPB Population Definition

Slide 4 of 8

Beneficiaries Included

- Enrolled in Medicare Part A & B for at least 90 days prior to inpatient admission
- Admitted to subsection (d) hospitals

Beneficiaries Excluded

- Enrolled in Medicare Advantage
- Medicare as a secondary payer
- Died during the episode
- Covered by Railroad Retirement Board

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MSPB Price Standardization Methodology

Slide 5 of 8

- Standardizes spending for each claim
  - Removes geographic payment rate differences, hospital-specific rates, and IME and DSH add-on payments
  - Substitutes national amount for services paid on basis of state fee schedule

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MSPB Risk Adjustment

- Accounts for case-mix variation across hospitals
- Risk-Adjustment Variables
  - Age
  - HCCs
  - Disability and ESRD Enrollment Status
  - Long-Term care
  - MS-DRG of Index Admission
- Separate Regression Model for each MDC

MSPB Measure Calculation

- Hospital
  - Add together all adjusted Medicare Part A and Medicare Part B payments for period
  - Divide sum of payments by total number of episodes for period
- Calculating the ratio

$$\frac{\text{Hospital's Medicare spending per beneficiary}}{\text{Median Medicare spending per beneficiary amount across all hospitals}}$$

MSPB Public Reporting for Hospital IQR

- CMS released MSPB preview report on February 1, 2012
  - Hospital preview period is February 1 – March 1, 2012
- Measure will be posted on Hospital Compare in April 2012
- Performance Period
  - May 15, 2010 through February 14, 2011
- Measure will be calculated on an annual basis
- Additional resources available at
  www.qualitynet.org

Calculations

- Add together higher of achievement or improvement score for each process measure in clinical process domain, weighting measures equally
  - Score achievement on scale of 0-10
  - Score improvement on scale of 0-9
- Divide by total opportunity for measures (=10*number of measures) and convert to percent (i.e., multiply by 100)
- For HCAHPs, sum higher of achievement or improvement score on each dimension and then add consistency score
  - Consistency on scale of 0-20
- Multiply domains by applicable weight
  - 70% Weight Clinical Process of Care domain
  - 30% Weight for Patient Experience of Care domain
- Add together weighted domain scores for total performance score
- Convert score to payment adjuster using linear exchange function

ACOs

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West Florida ACO, LLC
Trinity, FL

Advance Payment ACO Model Participants

Coastal Carolina Quality Care, Inc
New Bern, NC)

Jackson Purchase Medical Associates, PSC
Paducah, KY

North Country ACO
Littleton, NH

Primary Partners, LLC
Clermont, FL

RGV ACO Health Providers, LLC
Donna, TX

Bundled Payment

The Innovation Center
Proposed Models

Model / Feature	Model 1 Inpatient stay only	Model 2 Inpatient stay + post-discharge services	Model 3 Post-discharge services only	Model 4 Inpatient stay only
Eligible awardees	• Physician group practices • Acute care IPPS hospitals • Health systems • Physician-hospital organizations • Conveners of participating healthcare providers (conveners)	• Physician group practices • Acute care hospitals paid under the IPPS • Health systems • Physician-hospital organizations • Conveners	• Physician group practices • Acute care IPPS hospitals • Health systems • LTCHs • IRFs • HH agencies • Physician-hospital organizations • Conveners	• Physician group practices • Acute care IPPS hospitals • Health systems • Physician-hospital organizations • Conveners
Types of services included in bundle	• Inpatient hospital services	• Inpatient hospital & physician services • Related post-acute care •Related readmissions •Other services defined in bundle	• Post-acute care services • Related readmissions • Other services defined in bundle	• Inpatient hospital & physician services • Related readmissions

The Innovation Center

Proposed Models

Model / Feature	Model 1 Inpatient stay only	Model 2 Inpatient stay + post-discharge services	Model 3 Post-discharge services only	Model 4 Inpatient stay only
Expected discount provided to Medicare	Proposed by applicant; Minimum discounts increasing from 0% in first 6 months to 2% in year 3	Proposed by applicant; minimum 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	Proposed by applicant	Proposed by applicant; minimum discount of 3%; larger discount for MS-DRGs in ACE demo
Payment from CMS to provider	Acute care hospital: IPPS less pre-determined discount; Physician: FFS payment (not included in episode)	FFS to all providers and suppliers, subject to reconciliation with predetermined target price	FFS to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospital distributes payments
Clinical conditions	All MS-DRGs	Applicants propose based on MS-DRG for inpatient stay	Applicants propose based on MS-DRG for inpatient stay	Applicants propose based on MS-DRG for inpatient stay
Quality measures	All hospital IQR measures & measures proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		

Benefits & Measureable Goals – Summary

Premier Collaborative

Item	Benefits	Measureable Goals
1. Application Support	Utilize application preparation experience to reduce time and cost	• Investment time and cost reduced vs individual effort • Application accepted
2. Education	Leverage expert materials from a wide spectrum knowledge base	• Five learning sessions conducted • Majority participation
3. Episode Definition	Obtain a quicker, less expensive, and consistent claims and analytical process	• Episode condition, timeframe and excluded services determined • Bundled discount methodology completed
4. Measurement Development (Triple Aim)	Acquire standard performance metrics to improve patient care, health outcomes and identify improvement opportunities	• Selection of performance metrics identified and formulated • Develop episode tracking scorecard
5. Care Redesign/Care Model Development	Attain evidence-based standardization of care for quality improvement	• Care redesign education provided • Care re-design / model guidelines developed / provided
6. Gainsharing Incentive Planning	Engage physicians in effective partnerships, rewarding high quality performance	• Gainsharing model approved, by CMS • Gainsharing model adopted, by organization and physicians
7. Cost Reduction Identification	Improve efficiencies and reduce input costs to protect shared margin	• Margin on discounted Medicare episode increased, beyond prior baseline margin

Physician Payment

Physicians

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- Independent Payment Advisory Board
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Transparency in industry financial relationships

- Timeline:
  - March 2011: CMS special forum on potential additional forms and nature of payments
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Postponed!

Who must report?

- Physician-owned GPOs
- Manufacturers of a drug, device, biological or medical supply

Payment of value

- Physician
- Teaching hospital

Transparency of industry relationships

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    - Require manufacturers to report payments made to <u>all</u> health professionals who have prescribing privileges
  - Covered drug, device, biological, or medical supply
    - Support excluding over-the-counter drugs/biologics and medical devices/supplies for which FDA premarket approval or premarket notification is not required
  - Public Reporting
    - Information must be comprehensive, specific, meaningful and easily searchable by the public
    - Support 45-day review period

Health Reform Provisions in Effect: 2010

- Review of health plan premium increases
- Changes in Medicare provider rates
- Qualifying therapeutic discovery project credit
- Medicaid and CHIP Payment Advisory Commission
- Comparative effectiveness research
- Prevention and Public Health Fund
- Medicare beneficiary drug rebate
- Small business tax credits
- Medicaid drug rebate
- Coordinating care for dual eligibles
- Generic biologic drugs
- New requirements on non-profit hospitals
- Medicaid coverage for childless adults
- Reinsurance program for retiree coverage
- Pre-existing condition insurance plan
- New prevention council
- Consumer website
- Tax on indoor tanning services
- Expansion of drug discount program
- Adult dependent coverage to age 26
- Consumer protections in insurance
- Insurance plan appeals process
- Coverage of preventive benefits
- Health centers and the national health service corps
- Health care workforce commission
- Medicaid community-based services

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Health Reform Provisions in Effect: 2011

- Minimum medical loss ratio
- Closing the Medicare drug coverage gap
- Medicare payments for primary care
- Medicare prevention benefits
- Center for Medicare and Medicaid Innovation
- Medicare premiums for higher-income beneficiaries
- Medicare Advantage payment changes
- Medicaid health homes
- Chronic disease prevention in Medicaid
- National quality strategy
- Changes to tax-free savings accounts
- Teaching health centers
- Funding for health insurance exchanges
- Nutritional labeling
- Medicaid payments for hospital-acquired infections
- Graduate medical information
- Medicaid long-term care services

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Health Reform Provisions in Effect: 2012

- Accountable care organizations in Medicare
- Uniform coverage summaries for consumers
- Medicare Advantage plan payments
- Medicare independence at home demonstration
- Fraud and abuse prevention
- Annual fees on pharmaceutical industry
- Data collection to reduce health care disparities
- Medicare value-based purchasing
- Reduced Medicare payments for hospital readmissions

IPPS FFY 12

Hospital Inpatient Quality Reporting

Summary Payment FY 2014

- Retired 4 and adds 3 quality measures (total of 55) for payment in FY 14
  - Did not add Central Line Insertion Practice Adherence Percentage (CLIP) process measure
  - Surgical site infection collection limited to colon and hysterectomy procedures
  - Adds Efficiency Measure: Ratio of hospital Medicare Parts A and B spending per beneficiary to median for all hospitals
    - 3 days prior to admission, 30 days after admission
  - Adds structural measure for participation in Surgical Registry
  - Adds one Hospital-acquired Infection measure: Catheter Associated Urinary Tract Infection

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Hospital IQR Program for FY 2014 Payment

(Slide 1 of 3)

- Retire 4 chart-abstracted measures
  - Applies to FY 2014 payment
  - End data collection effective with January 1, 2012 discharges

Topped Out per CMS Analysis
AMI-4 Adult Smoking Cessation Advice/Counseling
HF-4 Adult Smoking Cessation Advice/Counseling
PN-4 Adult Smoking Cessation Advice/Counseling

Unintended Consequences
PN-5c Timing of Receipt of Initial Antibiotic following hospital arrival (within 6 hours)

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Hospital IQR Program for FY 2014 Payment
(Slide 2 of 3)

- Suspend data collection
  - Effective with January 1, 2012 discharges
  - Defined and used by TJC as accountability measures
  - Enables CMS to resume data collection if performance declines

Suspended from CMS Data Collection
AMI-1 Aspirin at Arrival
AMI-3 ACEI/ARB for LVSD
AMI-5 Beta-blocker Prescribed at Discharge
SCIP-INF-6 Appropriate Hair Removal

Hospital IQR Program for FY 2014 Payment
(Slide 3 of 3)

- Retain 52 of the existing quality measures
- Added Catheter Associated Urinary Tract Infection (CAUTI) through NHSN
  - Data collection would start with January 1, 2012 events
- Added Participation in a Systematic Clinical Database Registry for General Surgery
- Added Medicare Spending per Beneficiary
  - CMS will provide a public use file so hospitals can calculate their historical Medicare spending per beneficiary amounts

Hospital IQR for FY 2015 Payment
(Slide 1 of 3)

- Retains the 55 measures from FY 2014 payment
- Add 17 measures to FY 2015 payment for a total of 72
  - Stroke (8)
  - Venous Thrombo Embolism (6)
  - Healthcare-associated Infections via NHSN
    - MRSA
    - Clostridium Difficile
    - Healthcare Provider Influenza Vaccine

Hospital IQR for FY 2015 Payment
(Slide 2 of 3)

- Finalized the Stroke and VTE chart-abstracted measures beginning with January 1, 2013 discharges
  - CMS is working with relevant stakeholders to align the chart abstracted and e-measure specifications

Stroke
STK-1 VTE Prophylaxis for Patients with Ischemic or Hemorrhagic Stroke
STK-2 Ischemic Stroke Patients Discharged on Antithrombotic Therapy
STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter
STK-4 Thrombolytic Therapy for Acute Ischemic Stroke Patients
STK-5 Antithrombotic Therapy by End of Hospital Day Two
STK-6 Discharged on Statin Medication
STK-8 Stroke Education
STK- 10 Assessed for Rehabilitation Services

Venous Thromboembolism (VTE)
VTE-1 Venous Thromboembolism Prophylaxis
VTE-2 Intensive Care Unit (ICU) VTE Prophylaxis
VTE-3 VTE Patients with Anticoagulation Overlap Therapy
VTE-4 VTE Patients Receiving Unfractionated Heparin with Dosages/ Platelet Count Monitoring by Protocol
VTE- 5 VTE Discharge Instructions
VTE- 6 Incidence of Potentially Preventable VTE

Hospital IQR for FY 2015 Payment
(Slide 3 of 3)

- HAI measures

HAI measure	Data collection
Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia	Data collection starts with January 1, 2013 events
Clostridium Difficile SIR	

Healthcare Personnel (HCP) Influenza Vaccination

Data collection will cover January 1, 2013 through March 31, 2013 for FY 2015 payment

- Future payment determinations data collection will cover the October 1st through March 31st to coincide with Flu season

Hospital IQR Data Submission Timelines

- CMS decided to keep the current data submission timelines for chart abstracted measures
  - 4½ months after quarter end
  - Population and sample size count submission 4 months after quarter ends
- Structural measures
  - CMS is aligning structural measure collection with chart abstracted submission
  - Submission timeframe moves to April 1 – May 15
    - FY 2013
      - Provide information with respect to time period of January 1, 2011 through December 31, 2011 during April 1 – May 15, 2011
- HCAHPS
  - One week earlier to allow for review and correction period

Hospital IQR Data Validation
(Slide 1 of 2)

- Finalized hospital selection process to ensure all eligible hospitals selected for validation at least once every 4 years
  - Start with FY 2015
- Add 3 charts (total of 15) per quarter to validate CLABSI measure using a two step process to target ICU patients with CVC and Bloodstream infection
  1. CMS contractor require the 800 sampled hospitals to provide a quarterly list of all Blood Cultures positive for infection status taken from ICU for the discharge quarter
     a. Hospitals will identify ICU patients with Central Venous Catheter
  2. CMS contractor will randomly sample the provided list and select up to 3 records per quarter

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Hospital IQR Data Validation
(Slide 2 of 2)

- EDT and Immunization validation
  - Adding 3 records
    - Selected for principal diagnoses and surgical procedures not included in AMI, HF, PN and SCIP
  - Also using the AMI, HF, PN and SCIP records to validate EDT and Immunization measures
- FY 2014 payment determination will validate 18 records across 6 strata/samples

(1) SCIP	(2) AMI
(3) HF	(4) PN
(5) CLABSI • will also use the SCIP, AMI, HF & PN records	(6) EDT/Immunization • will use all records submitted for validation

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PHYSICIAN PAYMENT

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