Quality, Cost and Business Intelligence in Healthcare

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Where are we going?

2020

ACCOUNTABLE FOR HEALTH

VIRTUAL MEDICAL HOME

- Personalized medicine
- Coordination of care
- Facilitated access
- Electronic Health Record

- Evidence and Research
- Clinical Trials
- Predictive modeling analytics

Outcomes measurement = Value

Total cost

Deliberation

Delivery Contract

Incentive alignment

New payment models

FEARORS
- Cost
- Value
- Risk
- Equity
- Quality
- Access
-population
- Chronic conditions
- Declining workforce
- Connected customers

INDIVIDUAL ENGAGEMENT

nutrition • goals • education • activity-tracking

PERFORM more measurement
- Regulatory requirements
- Workforce shortage
- Digital infrastructure

Long-term care

School

Church

Gym

Relief

Hosp</ref>l
# Financial Impact CMS Quality Initiatives

<table>
<thead>
<tr>
<th>Volume (under prospective payment system cost and charge reimbursement)</th>
<th>Value Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2009</strong></td>
<td><strong>2010</strong></td>
</tr>
<tr>
<td>Inpatient Quality Reporting Requirement (IQR, formerly RHQDAPU) (8 AMI, 4 HF, 7PN, 11 SCIP)</td>
<td></td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>1%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>1%</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>1%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
</tbody>
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Affordable Care Act Overview
Selected Provisions
August 2012

This chart provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. See next page for brief explanations of these provisions. Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit http://www.apha.org/advocacy/Health+Reform/ for more ACA resources.

Insurance Reform

- More people covered
  - Medicaid expansion
  - Insurance exchanges
  - Guaranteed issue
  - Kids under 26 covered
  - Min cov’g provision
- More benefits & protections
  - Essential benefits
  - Preventive services cov’g
  - Rate restrictions
  - No lifetime/annual limits
  - Uniform summaries
- Lower costs (consumers & government)
  - Exchange subsidies
  - Medical loss ratio (MLR)
  - Premium rate review
  - Medicare Advantage
  - Prescription drug rebates

Health System Reform

- Improved quality & efficiency
  - Accountable Care Orgs. (ACOs)
  - Medical homes pilots
  - Quality measure devel. & use
  - Incentive payments
  - Dual eligibles care coord.
- Stronger workforce & infrastructure
  - Comm.- & school-based-health centers
  - Medicaid provider payments
  - Medicare provider payments
  - NHSC loan repayment program
  - Public health workforce devel.
- Greater focus on public health & prevention
  - Prevention & Public Health Fund
  - Community Transform. Grants
  - Public education campaigns
  - Community health needs assessments
  - Nutritional labeling

Adapted from Dr. Donald Berwick’s presentation “The Triple Aim: Health, Care, and Cost: Public Health and the Health Care Transition,” given June 2012 at APHA’s mid-year meeting. Find this document at http://www.apha.org/advocacy/Health+Reform/ACA basics/.
Medicare Payment Tied to Quality

Exhibit 3. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future

# FY 2016 Inpatient Prospective Payment System (IPPS) Policy Changes

## Changes in Payment Rates under IPPS

<table>
<thead>
<tr>
<th>Description</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>If general acute care hospitals successfully participate in Hospital Inpatient Quality Reporting (IQR) &amp; demonstrate meaningful use of certified EHR</td>
<td>↑ 0.9% in operating payment rates</td>
</tr>
<tr>
<td>Hospitals that <strong>Do NOT</strong> successfully participate in IQR Program and do NOT submit required quality data</td>
<td>↓ 1/4(^{th}) reduction in market basket</td>
</tr>
<tr>
<td>Hospitals <strong>NOT</strong> a meaningful user of EHR</td>
<td>↓ ½ the market basket update for FY 2016</td>
</tr>
</tbody>
</table>

**Continued penalties for Readmission**

**Continued – 1 % penalty for hospitals in worse performing quartile under HAC Reduction Program**

**Continued bonuses and penalties for hospital Value Based Purchasing (VBP)**
Potential Expansion of Bundled Payments for Care Improvement Initiative (BPCI)

BPCI initiative LINKS payments for multiple services during an episode of care into a bundled payment to improve continuity

BPCI episode initiated with: 1) Inpatient stay 2) post acute services following a qualified inpatient stay

Single payment amount for specific DRG

4 models tested across country:

- **Model 2** – acute and post acute care episodes
- Most popular with over 7000 providers opting in
- First year performance indicates **decrease in variation in use of post acute care** (major factor in healthcare spending across regions)
Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 Billion by 2017 to fully recoup documentation and coding OVERPAYMENTS related to DRGs that began in 2008.

For FY 2016, CMS is continuing FY 2014 approach by making another -0.8% adjustment.
Medicare Disproportionate Share Hospital (DSH) Program

CMS is distributing an estimated $6.4 billion in uncompensated care payments in FY 2016.

This decrease is attributed to continued declines in the number of uninsured individuals since ACAs passage.

This is a decrease of $1.2 Billion from the estimated FY 2015 amount.
Electronic Health Record Incentive Programs and Quality Reporting

Includes requirements for eligible hospitals and critical access hospitals participating in electronic reporting of clinical quality measures (CQMs) for EHR incentive programs and Hospital IQR Program.

CMS finalizing modifications to align the CQM reporting period and submission requirements.

Specific options for editions include:

- To specify the **options for the Editions of certified EHR technology providers may use**
- To establish **requirements** for the version of electronic specifications (eCQMs) a provider must use for **electronic submission of quality reporting data.**
Hospital Inpatient Quality Reporting (IQR) Program

Final Rule: CMS updating measures used in Hospital IQR Program

- Adding 7 new measures
  - 3 new claims based measures
  - 1 structural measure for FY 2018 payment determination & subsequent years
  - 3 new claims based measures for FY 2019 payment determination and subsequent years

- Finalizing changes in relation to eCQMs
  - CMS is extending its policy that hospitals not required to also chart-abstract and submit STK-01 if they submit the STK-02, STK-03, STK-04, STK-05, STK-06, STK-08, and STK-10 as electronic clinical quality measures for the CY 2015/FY 2017 payment determination

- CMS is finalizing modifications of its proposals and will require hospitals to submit four of 28 available eCQMs of their choice beginning in CY 2016 for the FY 2018 payment determination.

- Hospitals will be required to submit one quarter (either Q3 or Q4) of electronic data in CY 2016 by February 28, 2017.
Hospital Value Based Purchasing (VBP) Program

By ACA, Hospital VBP programs adjusts payments to hospitals for inpatient services based on their performance on a set of measures.

- **Addition of Care Coordination** measures beginning with FY 2018 program year
- **30 day mortality measure** for chronic obstructive pulmonary disease (COPD) beginning with FY 2021 program year
- Removal of 2 measures effective FY 2018 program year
- The rule signals future *policy changes that will affect certain National Health Safety Network measures* beginning with the FY 2019 program year.
CMS is finalizing:

- Dates and time period used to calculate hospital performance
- An expanded population for 2 measures that are already included in the program
- An adjustment to the relative contribution of each domain to the total HAC score
- An adjustment to the relative contribution of each measure within domain 2
- An extraordinary circumstance exception policy
CMS is finalizing:

- A refinement of the pneumonia readmission measure that expands the measure cohort
- Formal adoption of an extraordinary circumstance exception policy
- CMS is continuing to monitor the impact of **Socioeconomic** status of provider results in our quality programs
- Working with National Quality Forum on a 2 year trial to test **Sociodemographic** factor risk adjustment
- All part of the Improving Medicare Post Acute Care Transformation Act of 2014 (IMPACT Act)
A Look Ahead – New Value Based Reforms for Physician and Hospital Payment

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Healthcare Executive
September 2015
And it is not just Medicare

- 40% of states took on five or more initiatives
- 73% of states took on at least four initiatives
- Includes pay for performing to shared savings; (Medical Home, home health, Transition of care)

**FIGURE 1.** Number of Payment & Delivery System Reforms undertaken by State [2015]

Source: National Association of Medicaid Directors
“doc fix” – SGR to MIPS

• Sustainable Growth Rate (SGR) to Merit-Based Incentive Payment System (MIPS)
  • PQRS, MU and VBP payment adjustment continue till 2018 and in 2019 MIPS kicks in
  • SGR was the system that paid for Medicare. Now MIPS takes over

• Significant reward for participation in Alternative Payment Model
  • 5% if a physician is a qualified APM participant (25% threshold) starting in 2019 (2021 – 50% tied to physician)
  • Threshold to be stair steps every two years ending at 75% by 2025

• MIPS score’s maximum impact on reimbursement
  • Increases from +/- 4% for the 2019 to +/- 9% for the 2022 and subsequent payment years
  • Only effects EDs (doctors billing for part B services)

• To be better rewarded for what remains paid under FFS
  • Participation in APMs or PCMH substantially meets clinical practice improvement score
  • SGR “fix” includes better payment long term for traditional PFS FFS (only physicians that score well on quality now get paid)

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
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<tbody>
<tr>
<td>1st 3 weighted and scored</td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>30</td>
</tr>
<tr>
<td>Resource use</td>
<td>30</td>
</tr>
<tr>
<td>MU</td>
<td>25</td>
</tr>
<tr>
<td>Clinical practice improvemt (Dr.piece)</td>
<td>15</td>
</tr>
</tbody>
</table>
Care management central to CMS reform plans

- **Chronic care management benefit under Physician Fee Schedule (PFS)**
  - 2015 changes calls for one payment to be made for overall care management to responsible provider
  - Proposed to be extended to Hospital Outpatient Department, FQHCs and RHCs in 2016 OPPS and PFS rulemaking
  - **New billing code** – 1 facility can bill $45/month/beneficiary (PCP). Consider cost sharing with different levels of care

- **Episodic bundle payment tied to hospitalization**
  - Hospital BPCI models 2 to 4 pay risk bearing entity for bundle conditions inclusive of post acute services
  - **New CMS proposal** for Comprehensive Care for Joint Replacement builds on BPCI concept but with mandated participation unless hospital meets exempt conditions including by participation in BPCI Models 1, 2 or 4

- **Proliferation of Medicare spending measures** marks transition from process to outcome based measures
  - Hospital IQR and value based payment
  - Physician value based payment modifier
Beyond BPCI - Comprehensive Care for Joint Replacement (CCJR)

First Mandated Episode Based Bundled Payment

Proposed Rule
Final Rule in November
All subject to change
Eligibility

Short term acute are hospitals paid under the IPPS
Looking at charges from multiple provider types across continuum
Looking at specific costs per episode

Hospitals in Maryland are excluded

Hospitals participating in BPCI Models 1, 2, or 4 are excluded

Hospitals are included based on their location in a Metropolitan Statistical Area (MSA) as defined by Office of Management & Budget at a county level

- This requires that the MSA have an urban core population of at least 50,000
- List of affected MSAs and counties can be found [here](#)
Metropolitan areas included in the initiative

Source: HHS
Two Sided Risk Model

The anchor hospital bears full responsibility for the episode cost

Can enter into cost agreements

Can offer beneficiary agreements

CCJR Bundled Payment is a retrospective calculation

A comparison of net costs to net target costs
- 60 day claim run off after episode year

Calculation occurs Q2 following year, and again a year later

2017 will be the first year of downside risk

2016 only upside and then Risk will be phased in with a discount in target price

Mandatory CQMs must be successfully submitted to receive a reconciliation payment
Episode Definition

Begins with admission to an eligible hospital for a lower extremity joint replacement (LEJR)

- MS-DRG 469 is major joint replacement or reattachment with Major complication or comorbidity (MCC)
- MS-DRG 470 is major joint replacement or reattachment without MCC

Includes most Medicare Part A or B 90 days post discharge

- A few exceptions are listed related to certain chronic conditions
- Exceptions are the same as for BPCI LEJR
- A list of exclusions by ICD-9 (will be updated to ICD-10) can be found here
- **Hospital bills for surgery but doesn't have outpatient claims (included in Part A & B post 90 day discharge). Consider Cost sharing agreements.**

An episode will be excluded if:

- A patient is admitted to another hospital for MS-DRG 469 or 470
- A patient dies during the hospitalization
- A patient initiates an LEJR episode under Models 1, 2, 3, 4
### Episode Inclusion by Year

Nov/Dec prior to performance year, prices for episodes of care based on market released

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Start</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Episodes beginning on or after January 1, 2016</td>
<td>Episodes that end on or before Dec 31, 2016</td>
</tr>
<tr>
<td>2017</td>
<td>Episodes that end on or after January 1, 2017</td>
<td>Episodes that end on or before December 31, 2017</td>
</tr>
<tr>
<td>2018</td>
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<td>2020</td>
<td>Episodes that end on or after January 1, 2020</td>
<td>Episodes that end on or before December 31, 2020</td>
</tr>
</tbody>
</table>
**Target Episode Prices**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target prices will be created for each MS-DRG</td>
<td></td>
</tr>
<tr>
<td>Target prices will be provided before each reporting period</td>
<td></td>
</tr>
<tr>
<td>There will be 8 target prices 2016 and 2018-2020 (16 for 2017)</td>
<td></td>
</tr>
<tr>
<td>Target price created for January through September and for October through December</td>
<td></td>
</tr>
<tr>
<td>Regional and hospital specific episode prices are capped at 2 standard deviations over the mean</td>
<td></td>
</tr>
</tbody>
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Target Price Considerations
*For baseline and threshold targets

Target Prices include the following considerations:

- 3 years historical data
- Blend of regional and hospital specific claims
- Application of payment systems (IPPS, PFS, OPPS, etc)
- Wage normalization
- Pooling and weighting of MS-DRG 469 and 470
- A discount target prices

For baseline and threshold targets
Quality Measures

3 mandatory CQMs

- Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551)
- Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550)
- HCAHPS Survey measure.

Voluntary Measure

- Patient Reported Outcomes following elective primary THA or TKA measure of both
- Successful submission = reduction of discount in target price

Threshold must be met to receive reconciliation payment

- 30% threshold years 1-3 to get reimbursed and 40% threshold in years 4 and 5 to get reimbursed
Cost Sharing Agreements

- Hospitals can enter into Cost Sharing Agreements
  *Share risk with other levels of care

- Cannot be a loan or require referrals for business

- Hospital must retain responsibility for 50% of total cost

- No CCJR Collaborator can take on more than 25%

- Hospital is responsible for enforcement of participants
The Future of Healthcare
Thank you!

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