Quality via payment incentives

Previously, quality via

liability

licensing

Background

Never events

Readmission penalties

Value Based Purchasing

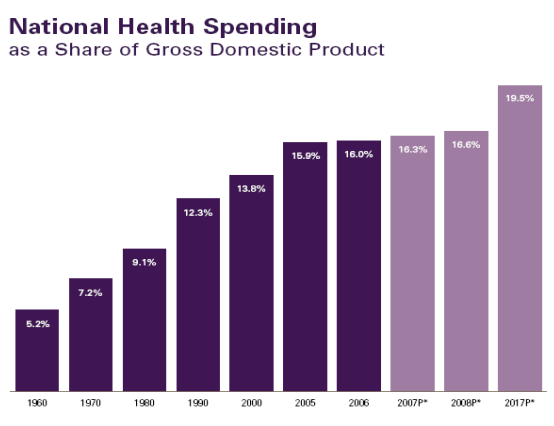
ACO quality measures

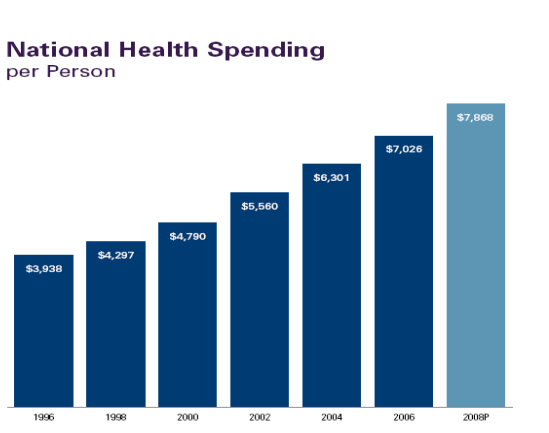
False Claims Act

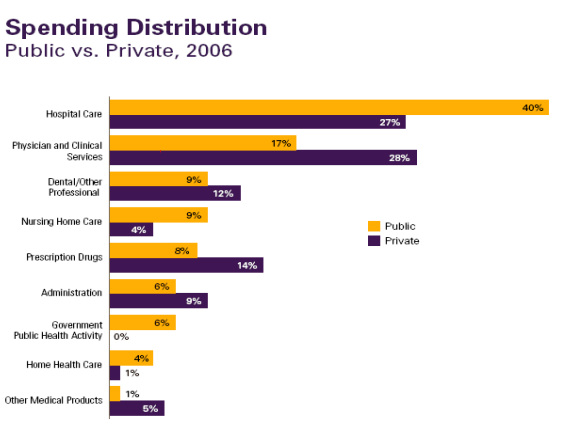
Background

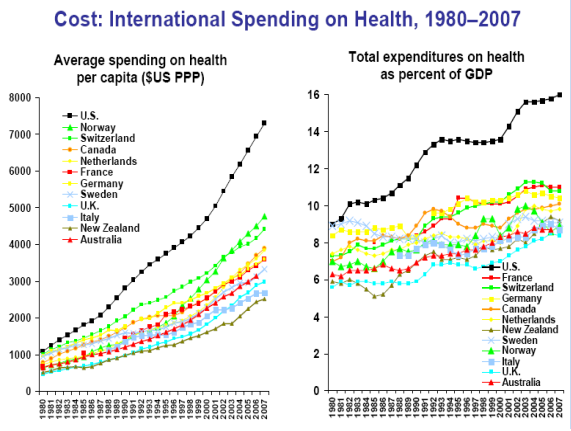
High cost

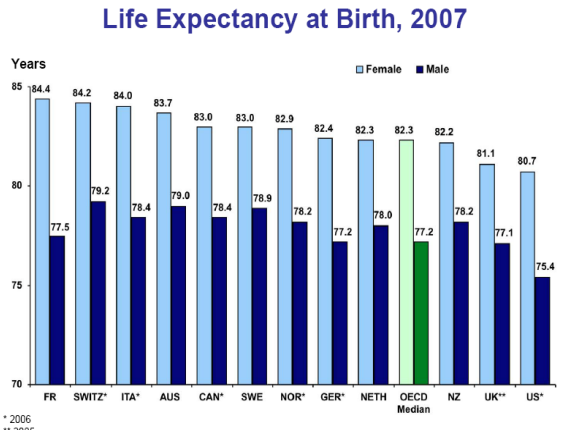
Low value











Fee for service

Payment based on **volume** of services

More you do → more you make

"You have excellent insurance, I'm sure we'll be able to find something wrong with you."

Most healthcare still paid FFS

Shifting from

Volume → Value

as basis of reimbursement

Moving from FFS to PFP (pay for performance)

Physicians are paid for **each service** they furnish

Hospitals are paid in a **more bundled** manner, but still for each admission

Change in the market will be from accountable for volume only to accountable for **cost and quality outcomes**

Medicare

Part A

A C

B D

Part A

Inpatient Hospital

Skilled Nursing Facility (limited to 100 days after H)

Hospice

$1000 deductible

Part B

Outpatient Hospital

Physician Services

Ambulance

Durable Medical Equipment

$100/mo premium (amount **somewhat** means tested)

Prior to 1983, Medicare paid fee-for-service based on charges

In 1983, Medicare started paying based on "**Diagnostic Related Groups**"

→ shifts risk to hospitals

DRGs are the ~500 most common reasons why people are hospitalized

DRGs classify patients:

- Into clinically cohesive groups
- Each group demonstrates similar hospital resource consumption and length-of-stay

The **last** "mathematical" formula of the semester, really

Components of amount calculation:

- DRG relative weight
- Standardized amount
- Add-ons

http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortB...

DRG	Dx	Weight
143	Chest pain	0.58
127	Heart failure/shock	1.16
103	Heart transplant	15.5

What if you coded and billed chest pain as congestive heart failure?

Case Mix Index (CMI)

Average DRG weight for all of a hospital's Medicare volume

DRG weights for all Medicare discharges

Number of discharges

Components of amount calculation:

DRG relative weight

Standardized amount

Add-ons

Standard amount

~$6000

Adjusted for wage index variations

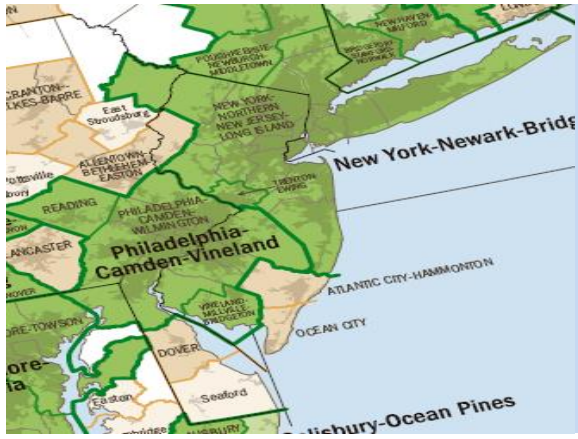


Table 1: Clinical Categories of Workers Included in the OMA

Clinical Occupation Class	Included Categories of Workers
Nursing	RNs, LPNs, Nurse Aides, Medical Assistants
Physical Therapy	Physical therapists, PT assistants, PT aides
Occupational Therapy	Occupational therapists, OT assistants, OT aides
Respiratory Therapy	Respiratory therapists, RT technicians
Pharmacy	Pharmacists, Pharmacist technicians, Pharmacist assistants
Dietary	Dietician, Diet technician
Medical and Clinical Laboratory	Lab technologist, Lab technician

DRG	Dx	Weight	Reim
143	Chest pain	0.58 x $5000 =	$2900
127	Heart failure/ shock	1.16 x $5000 =	$5800
103	Heart transpl.	15.5 x $5000 =	$77,500

Components of amount calculation:

DRG relative weight

Standardized amount

Add-ons

Add-ons

Teaching hospital

Disproportionate share of indigent

Sole community hospital

Outlier costs

Reimbursement =

(DRG relative weight

x

Standard amount)

+

Add-ons

Benefits

Relative simplicity

Incentivizes hospitals to:

Account for costs they control

Improve productivity

Specialize in the types of cases they can do most efficiently

Problems

Discharge "quicker and sicker"

No adjustments for severity

Never events

Deny reimbursement for costs of treating certain **hospital acquired conditions**

Errors **clearly identifiable and measurable** and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization

Surgical Events

Surgery performed on wrong body part

Surgery performed on wrong patient

Wrong surgical procedure on a patient

Retention of a foreign object

Intraoperative or immediately post-operative death in a normal healthy patient

Product or Device Events

Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics

Patient death or serious disability associated with device used other than intended

Patient death or serious disability associated with intravascular air embolism

Patient Protection Events

Infant discharged to the wrong person

Patient death or serious disability associated with patient disappearance > 4 hours

Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

Care Management

Patient death or serious disability associated with a medication error

Patient death or serious disability associated with a hemolytic reaction due to transfusion of the wrong blood type

Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy

Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility

Environmental Events

Patient death or serious disability associated with an electric shock

Any incident in which a line designated for oxygen or other gas contains the wrong gas or is contaminated by toxic substances

Patient death or serious disability
- associated with a burn
- associated with a fall
- associated with the use of restraints or bedrails

Criminal Events

Any instance of care ordered by or provided by someone impersonating licensed provider

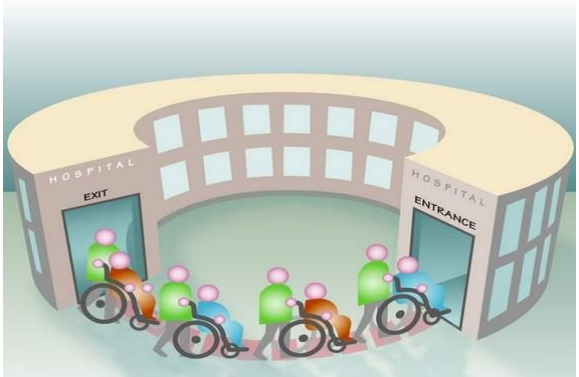
Abduction of a patient of any age

Sexual assault on a patient within or on the grounds of a healthcare facility

Death or significant injury of a patient or staff member resulting from a physical assault

Many **private** insurers follow Medicare on this (and on most policies)

Readmissions



1 in 5 in 30 days 1 in 3 in 90 days

Hospital Readmissions Reduction Program (Oct. 1, 2012)

ACA 3025, 42 USC 1886q, 42 CFR 412.150-54

Hospitals with excess numbers of patients returning **within 30 days** of discharge following treatment for heart attack, heart failure and pneumonia

Medicare payments for all patients docked

- up to 1% in FY 2013
- up to 2% in FY 2014
- up to 3% in FY 2015

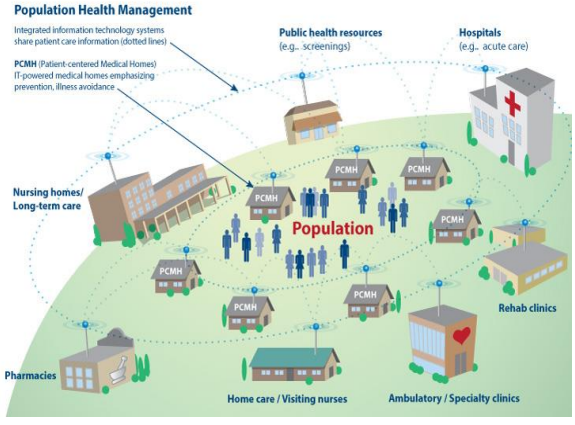
FY 2015

> 2600 hospitals will see Medicare payments docked

Complications from treatments received during a hospital stay

Inadequate treatment

Inadequate care coordination and follow up care in the community



Value Based Purchasing Program

Lose or gain percentage of regular Medicare reimbursements based on **performance** on 24 measures

3 types of measures

- Process
- Patient satisfaction
- Mortality

Process measures 45%

Clinical guidelines

e.g. Averting Blood Clots in Heart Attack Patients. Percent of heart attack patients given medication to avert blood clots within 30 minutes of arrival at the hospital.

e.g. Prompt Antibiotic Treatment. Percent of patients that received an antibiotic within an hour of surgery.

Patient satisfaction 30%

Percent of patients who said they "always" had a favorable experience:

- e.g. How well nurses communicated
- e.g. How well doctors communicated
- e.g. How clean and quiet the hospital room and hall were

Mortality rates 25%

among Medicare patients admitted

- heart attack
- heart failure
- pneumonia

1.25%

1.5% in Oct. 2014

Eventually 2%

ACO

Organization of providers that agree to be accountable for quality, cost, overall care of beneficiaries

>300 serving 5 million (10%) Medicare beneficiaries

Eligible to **share** in savings only if

1. There are savings
2. Meet quality performance thresholds

Patient/Caregiver Experience

ACO #1 Getting Timely Care, Appointments, and Information

ACO #2 How Well Your Doctors Communicate

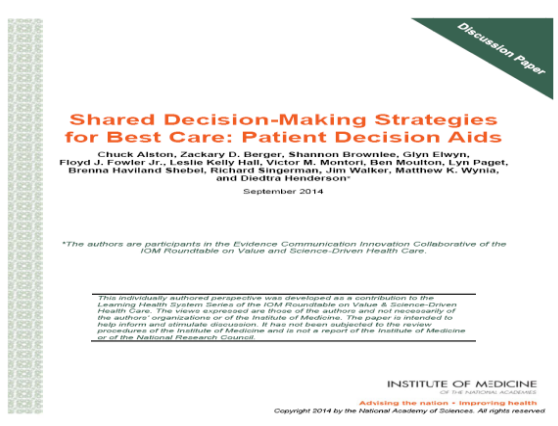
ACO #3 Patients' Rating of Doctor

ACO #4 Access to Specialists

ACO #5 Health Promotion and Education

ACO #6 Shared Decision Making

ACO #7 Health Status/Functional Status


Discussion Paper

Shared Decision-Making Strategies for Best Care: Patient Decision Aids

Chuck Alston, Zackary D. Berger, Shannon Brownlee, Glyn Elwyn, Floyd J. Fowler Jr., Leslie Kelly Hall, Victor M. Montori, Ben Moulton, Lyn Paget, Brenna Haviland Shebel, Richard Singerman, Jim Walker, Matthew K. Wynia, and Diedtra Henderson*

September 2014

*The authors are participants in the Evidence Communication Innovation Collaborative of the IOM Roundtable on Value and Science-Driven Health Care.

This individually authored perspective was developed as a contribution to the Learning Health System Series of the IOM Roundtable on Value & Science-Driven Health Care. The views expressed are those of the authors and not necessarily of the authors' organizations or of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine and is not a report of the Institute of Medicine or of the National Research Council.

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ACO #8 Risk Standardized, All Condition Readmissions

ACO #9 ASC Admissions: COPD or Asthma in Older Adults

ACO #10 ASC Admission: Heart Failure

ACO #11 Percent of PCPs who Qualified for EHR Incentive Payment

ACO #12 Medication Reconciliation

ACO #13 Falls: Screening for Fall Risk

Preventive Health

ACO #14 Influenza Immunization

ACO #15 Pneumococcal Vaccination

ACO #16 Adult Weight Screening and Follow-up

ACO #17 Tobacco Use Assessment and Cessation Intervention

ACO #18 Depression Screening

ACO #19 Colorectal Cancer Screening

ACO #20 Mammography Screening

ACO #21 Proportion of Adults who had blood pressure screened in past 2 years

At-Risk Population Diabetes

ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent)
ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL)
ACO #24. Blood Pressure (BP) < 140/90
ACO #25. Tobacco Non Use
ACO #26. Aspirin Use
ACO #27 Percent of beneficiaries with diabetes whose HbA1c in poor control
ACO #28 Percent of beneficiaries with hypertension whose BP < 140/90

At-Risk Population IVD

ACO #29 Percent of beneficiaries with IVD with complete lipid profile and LDL
ACO #30 Percent of beneficiaries with IVD who use Aspirin or other
ACO #31 Beta-Blocker Therapy for LVSD

At-Risk Population CAD

ACO #32. Drug Therapy for Lowering LDL Cholesterol
ACO #33. ACE Inhibitor or A