

HACs, Readmissions and VBP: Hospital Strategies for Turning Lemons into Lemonade

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The Triple Aim: Care, Health, And Cost

The remaining barriers to integrated care are not technical; they are political.

by Donald M. Berwick, Thomas W. Nolan, and John Whittington

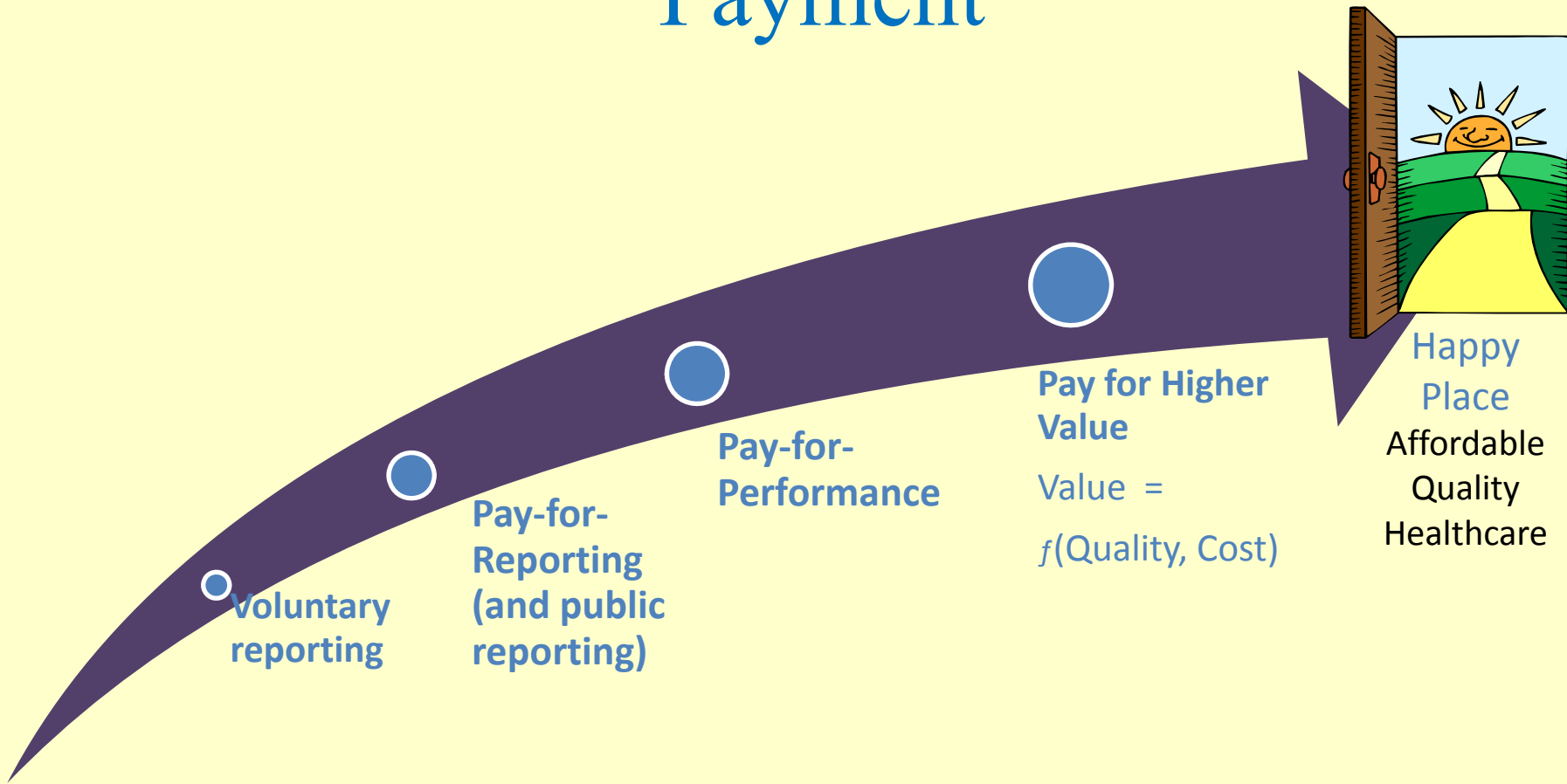
ABSTRACT: Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an or-

Donald M. Berwick, Thomas W. Nolan and John Whittington
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Health Affairs, 27, no.3 (2008):759-769

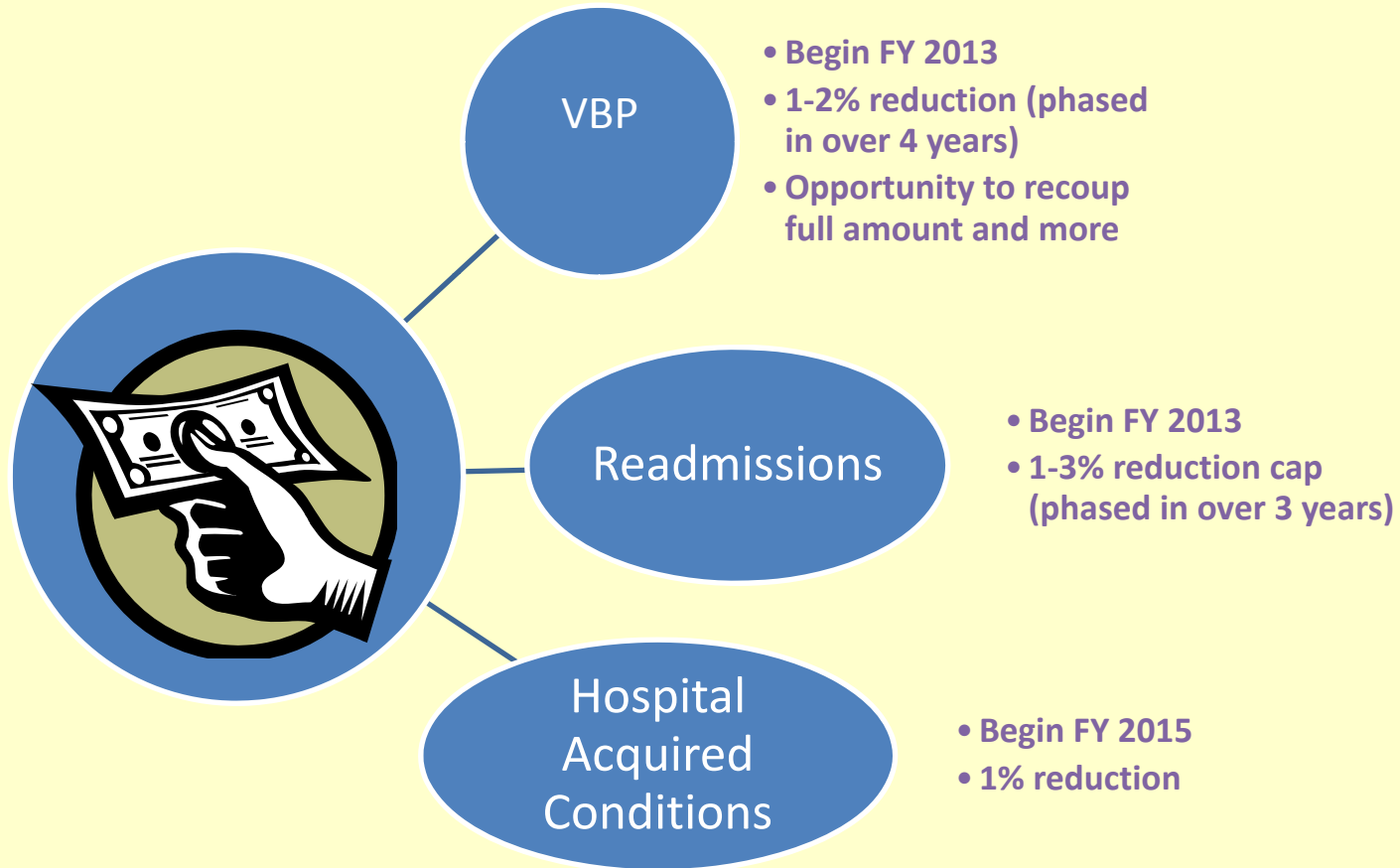
Value Based Purchasing

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care

Evolution of Quality Reporting and Payment



Percentage of Base DRG Payment at Risk Under ACA Quality Provisions



Potential to have 6% of base DRG payments at risk by 2017!

Hospital-Acquired Conditions (“HACs”)

Medicare Penalty – Bottom Line

- Section 3008 of the Affordable Care Act (ACA)
- Effective for FY2015 and subsequent years
- Hospitals in the top quartile as compared to national rates of HACs will have their Medicare payments for ALL DISCHARGES reduced by 1%

Bottom Line (cont'd.)

- Which HACs are included?
 - Those subject to the IPPS payment restriction
 - Other HACs specified by the Secretary
- Secretary determines the applicable performance period and is required to apply an appropriate risk-adjustment methodology
- Requires confidential reports to hospitals in the top quartile prior to FY 2015
- Requires public reporting and posting on Hospital Compare

Medicare HAC Non-Payment Provision

- Currently reporting 8 HAC “measures” adopted in the Hospital Inpatient Quality Reporting (IQR) Program

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
6. Catheter-Associated UTI
7. Vascular Catheter-Associated Infection
8. Manifestations of Poor Glycemic Control

- CMS proposed Acute Renal Failure as an additional HAC but delayed implementation due to coding concerns.

- HAC rates are calculated on CMS billing data for Medicare FFS only

Identifying a HAC

- Requires:

- A qualifying diagnosis code as the only secondary diagnosis or complication

- AND a POA value of “N” or “U”

- “N” = Diagnosis was not present at time of inpatient admission

- “U” = Documentation insufficient to determine if the condition was present at the time of inpatient admission

- If a HAC code is identified as the only secondary diagnosis/complication, the case will be paid as though the secondary diagnosis was not present

- OIG to review accuracy of POA coding



Medicare HAC Payment Policies Challenges and Concerns

- HAC “measure” methodology
 - HAC rate \neq measure
 - Not endorsed by the National Quality Forum (NQF)
 - Measure Application Partnership (MAP)
recommended not to include the current CMS HAC “measures” in any payment program and should be replaced by other NQF endorsed measures
- Quartile approach
 - No way to get out of the penalty box



Challenges and Concerns

- Variability in preventability
 - “reasonably” preventable?
- Potential “double jeopardy” due to inclusion in other payment programs
 - VBP, HAC non-payment program

Medicaid HAC Non-Payment Provision

- Section 2701 – Medicaid Payment Adjustment for HACs
- Framework for application of Medicare HAC non-payment program for Medicaid
- Effective July 1, 2012 (a delay from the proposed 2011 effective date)
- Final Rule sets Medicare policy as floor, allowing states some flexibility to make additional HACs subject to the policy
- Question as to the level of Federal oversight over state expansion of the Medicare policy

Hospital Readmissions

Readmission Payment Policy Background

- Section 3025 of the ACA
- Effective October 1, 2012 (FY 2013)
- All base DRG payment amounts (excluding IME, DSH, outliers) in hospitals with excess readmissions are reduced by a factor determined by the level of “excess readmissions”
- Reductions are based on a ratio of actual to expected risk-adjusted readmissions
- FY 2013, the policy will apply to heart attack, heart failure, and pneumonia
- FY 2015, the policy will be expanded to four additional conditions identified in the June 2007 MedPAC report (COPD, CABG, PTCA, Other Vascular) and other high volume, high expenditure conditions and procedures, as determined by the Secretary

Payment Formula

•**Step 1** – The formula determines the “excess readmissions ratio”
– This is defined as a ratio of the number of risk-adjusted readmissions (based on actual readmissions) for the given condition at a specific hospital compared with the number of readmissions that would be expected for an average hospital caring for the same patients.

•**Step 2** – The formula calculates the amount of aggregate payments due to excess readmission for each condition by multiplying the total number of admissions for the condition times the average base DRG payment for the condition times 1 minus the excess readmissions ratio for the condition

Formula = (1- excess readmission ratio) * number of admissions for condition * average base DRG payment amount for the condition

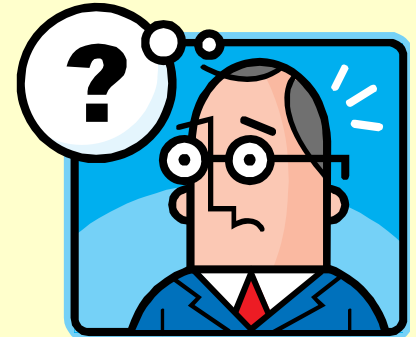
Measure Requirements

- Risk-adjusted actual and expected readmissions are to be determined consistent with measures that have been endorsed by the entity with a contract under section 1890(a) – i.e., the National Quality Forum
- Measures MUST have appropriate exclusions for certain readmissions such as a planned readmission, readmissions unrelated to the original admission, or a transfer to another hospital

How Do You Define “Such As”?

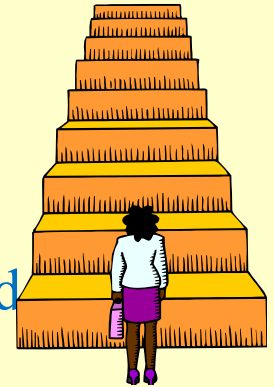
- The AMI readmission measure is the only measure that has exclusions for several planned procedures
- In the IPPS Final Rule, CMS finalized the measures without revision or modification
- No additional exclusions would be made for planned or unrelated readmissions

Outstanding Questions



- How will the payment calculation and reduction be implemented?
- What modifications will CMS make to the measure calculation or payment adjustment?
 - Stratification approach (FY2013)?
 - Exclusions for planned readmissions (FY2014)?
 - Exclude certain patients?

Challenges for Hospitals



- Readmission data on Hospital Compare does not facilitate rapid cycle improvement
 - Data is old by the time a hospital sees it
 - Data covers a 3 year-period which makes it difficult to effect readmission rates based on positive interventions
 - Hospitals cannot replicate the measure calculation
 - No access to Part B data
 - Uses proprietary software
 - No way to know whether a patient is readmitted to another facility

Challenges for Hospitals (cont.)

- 30-day window and all-cause don't tie closely enough to a hospital's performance
- Possible unintended consequences for vulnerable patient populations and the hospitals that treat those patients
- Interventions are costly

Revenues are Falling – Something Needs to Change

- Our analysis has indicated that hospitals need to reduce direct operating expenses by an average of 14% to sustain current margins at Medicare payment rates - Sg2, October 2010
- “Bottom line, if you attempt to use the same care delivery model moving forward, faced with the magnitude of reductions in forecasted revenue, you will go out of business “ - Sg2, October 2010

“You can’t save your way to prosperity” – Finan’s Laws, Ancient

VBP Rule Implementation

VBP Rule Implementation

- Overview
 - From October 1, 2012, hospitals that meet certain performance standards during a performance period are to receive incentive payments
 - The amount of the total DRG pool allocated to VBP rises from 1% in FY 2013 to 2% by FY 2017

VBP Rule Implementation (cont.)

- Applicable hospitals
 - Subsection (d) hospitals
 - Minimum number of qualifying cases
 - For FY 2013, at least 10 cases each pertaining to 4 Clinical Process of Care measures, and 100 HCAHPS surveys
 - For FY 2014, add at least 10 cases each for 2 Outcomes measures

VBP Rule Implementation (cont.)

- Quality indicators
 - For FY 2013, there were 13 indicators, including 12 Clinical Process of Care measures, and HCAHPS survey
 - For 2014, there are 17 indicators
 - Added one more Clinical Process of Care measure, plus three Mortality measures
 - Proposed, finalized, and retracted measures relating to efficiency, HACs and AHRQ composite measures

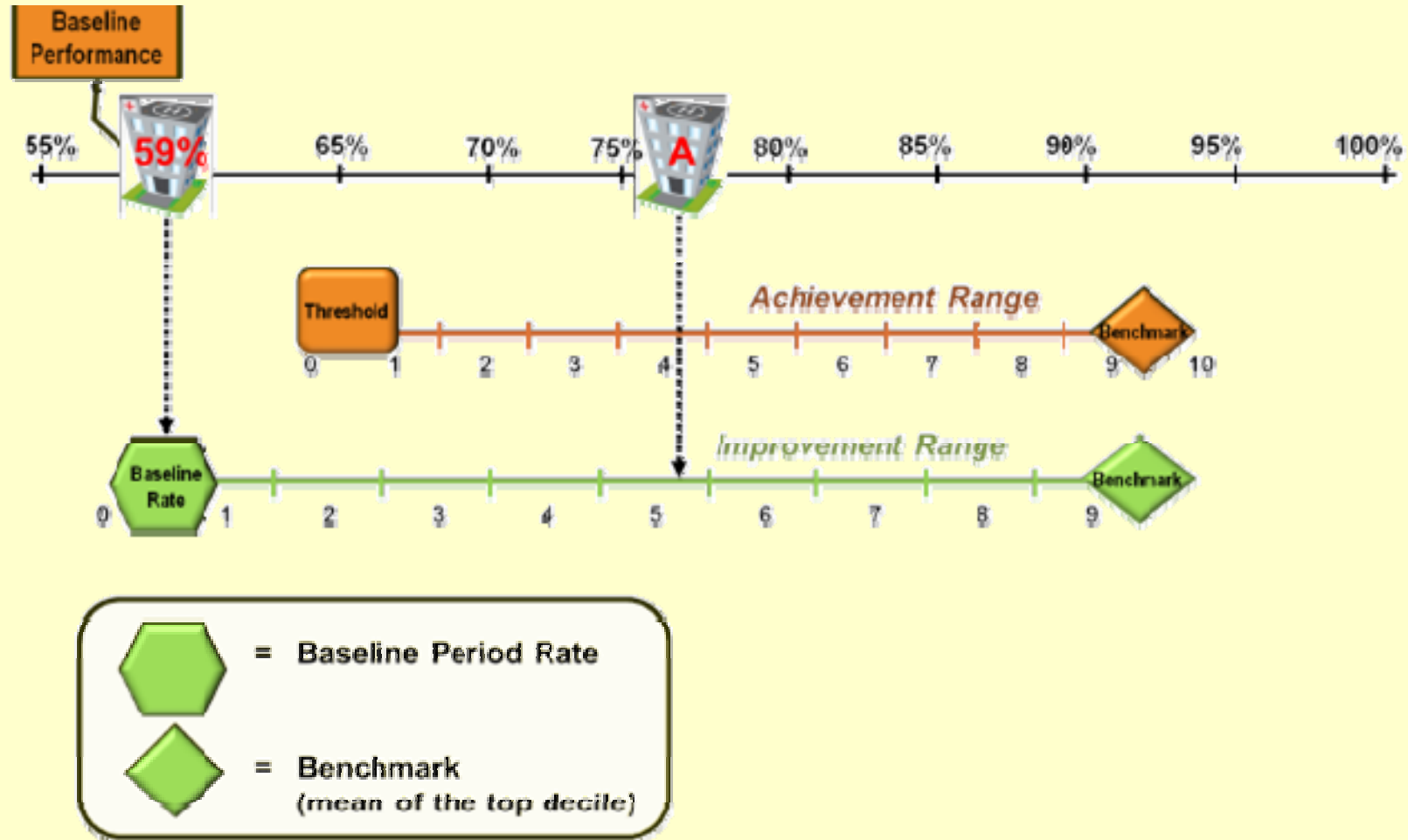
VBP Rule Implementation (cont.)

- Scoring
 - Both an “achievement” and an “improvement” score
 - “Achievement” is measured by falling between a threshold and a benchmark
 - Threshold is the 50th percentile from a baseline period
 - Benchmark is the median of the top decile during the baseline period
 - Many require a perfect score for top decile

VBP Rule Implementation (cont.)

- Scoring (cont.)
 - “Improvement” is measured by falling between an improvement threshold and a benchmark
 - Threshold is hospital’s own performance during a baseline period
 - Benchmark is the same as achievement score

VBP Rule Implementation (cont.)



VBP Rule Implementation (cont.)

74538 Federal Register / Vol. 76, No. 230 / Wednesday, November 30, 2011 / Rules and Regulations

FY 2014 Achievement Performance Standards for Clinical Process of Care Measures			
Measure ID	Measure Description	Performance Standard (Achievement Threshold)	Benchmark
Process of Care Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.8066	0.9630
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9344	1.0000
HF-1	Discharge Instructions	0.9266	1.0000
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9730	1.0000
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9446	1.0000
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9807	1.0000
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9813	1.0000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9663	0.9996

VBP Rule Implementation (cont.)

Federal Register / Vol. 76, No. 230 / Wednesday, November 30, 2011 / Rules and Regulations 74539

FY 2014 Achievement Performance Standards for Clinical Process of Care Measures			
Measure ID	Measure Description	Performance Standard (Achievement Threshold)	Benchmark
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	0.9634	1.0000
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	0.9286	0.9989
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	0.9565	1.0000
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.9462	1.0000
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	0.9492	0.9983

VBP Rule Implementation (cont.)

- Baseline and Performance Periods
 - FY 2013:
 - Baseline period is 7/1/09 to 3/31/10
 - Performance period is 7/1/11 to 3/31/12

VBP Rule Implementation (cont.)

- Baseline and Performance Periods (cont.)
 - FY 2014:
 - Clinical Process of Care & HCAHPS
 - Baseline period is 7/1/09 to 6/30/10
 - Performance period is 7/1/11 to 6/30/12
 - Outcomes
 - Baseline period is 4/1/10 to 12/31/10
 - Performance period is 4/1/12 to 12/31/12

VBP Rule Implementation (cont.)

- Domains

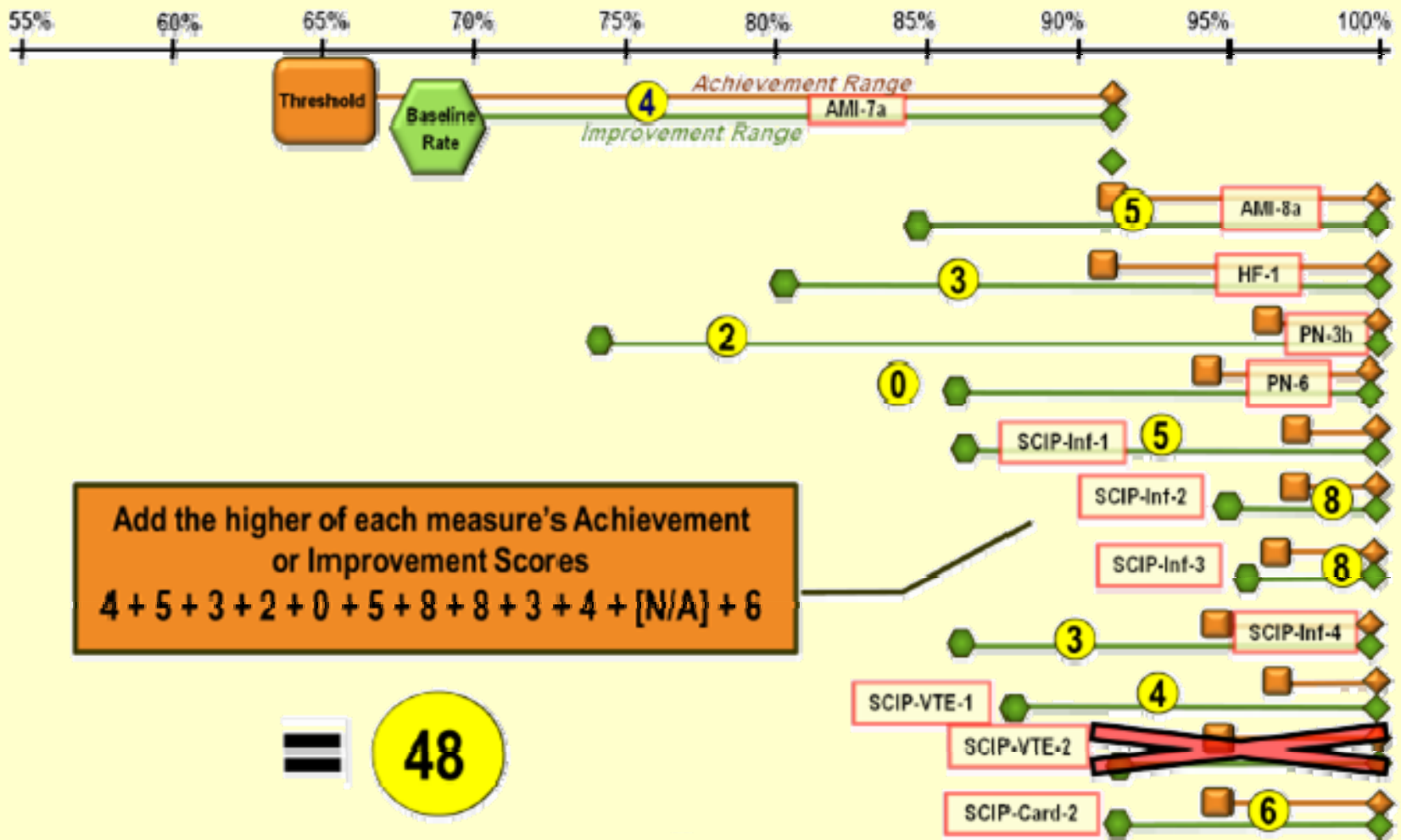
- FY 2013

- Clinical Process of Care - 70%
 - HCAHPS – 30%

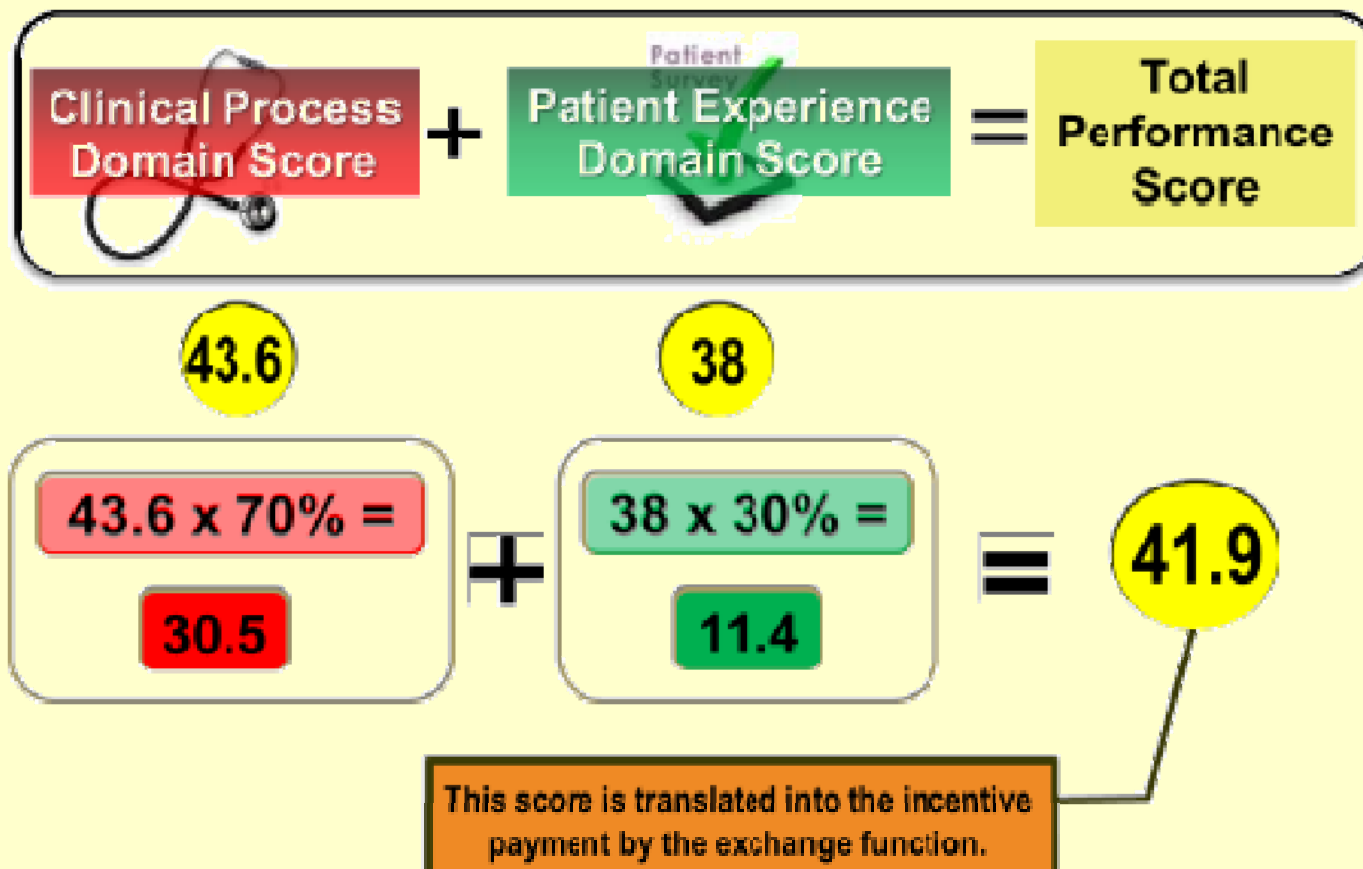
- FY 2014

- Outcomes - 25%
 - Clinical Process of Care - 45%
 - HCAHPS – 30%

VBP Rule Implementation (cont.)

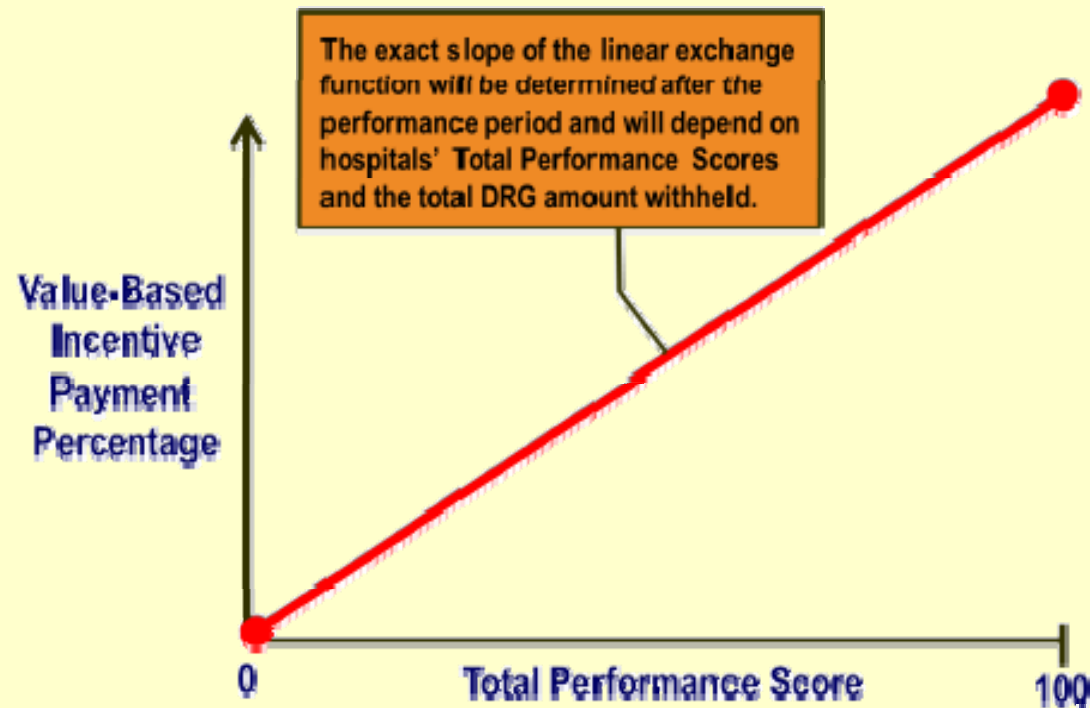


VBP Rule Implementation (cont.)



VBP Rule Implementation (cont.)

- Payment
 - Linear function



VBP Rule Implementation (cont.)

- Efficiency Indicator

- Proposed to be included in FY 2014, but not finalized
- Includes an episode of care that begins 3 days prior to admission and continues to 30 days post-admission
- Includes all Medicare payments, both Part A or Part B payments, with very limited exceptions
- Risk adjusted for health factors only, not demographics

VBP Rule Implementation (cont.)

- Efficiency Indicator (cont.)
 - Data to be made available to hospitals before publication
 - The broad coverage of the episode is supposed to incentivize hospitals to coordinate care with others in the community
 - Would have accounted for a domain of 20% all by itself; may still be weighted as high when finally adopted, likely in 2015

Review and Correction of Quality Data

Review and Correction of Quality Data

- Payment and reputational consequences
 - Unfavorable results in HAC, Readmission, and VBP scores can cause payment reductions
 - All of these quality data points also appear on Hospital Compare, which is available for consumers and other payers to see

Review and Correction of Quality Data (cont.)

- HAC and VBP Clinical Process of Care data review process
 - Reported through IQR and can be disputed accordingly
 - Hospitals have until 4.5 months from date of last discharge to correct data
 - No process yet for seeking corrections to mortality or efficiency measure data
 - Will have 60 days to review final calculation, but likely will not be able to challenge any data that had previously been available through IQR review process or otherwise
- Readmissions data review process
 - Hospitals will be given 30 days to review data before data is published.

Review and Correction of Quality Data (cont.)

- Readmissions data review process
 - Hospitals will be given 30 days to review data before data is published.

Appeal Rights

Appeal Rights

- VBP
 - What *cannot* be appealed
 - Value-based incentive payment determination methodology
 - Determination of the amount of funding available for incentive payments and payment reduction
 - Establishment of the performance standards and performance period
 - Measures specified in the Hospital IQR program or included in Hospital VBP
 - Methods and calculations for total performance scores
 - Validation methodology used in the Hospital IQR program

Appeal Rights (cont.)

- What likely will be appealable
 - How hospital's data was converted to a score
 - Accuracy of data items used in calculating score (presuming preservation of appeal rights)
 - Calculation of a measure's numerator or denominator

Appeal Rights

- Appeals process
 - ??

Avoiding Adverse Quality Data Outcomes

- Operational
 - CMS suggestions
 - Ensure patients are ready for discharge and understand discharge plans
 - Reconcile medications
 - Improve communication with community providers
 - Participate in home-based follow-up
 - Review cases in the baseline period and determine what could have been done differently
 - Track patients carefully for at least 30 days

Avoiding Adverse Quality Data Outcomes (cont.)

- Operational (cont.)
 - Get BOD, MEC, and individual physician buy-in.
 - OIG has identified that BOD involvement in quality of care issues is necessary to avoid fraud and abuse violations
 - Build it into compliance policies
 - Legal risks now associated with errors in the medical record, such as FCA liability
 - CMS has stated that improper HAC information could result in OIG referral

Avoiding Adverse Quality Data Outcomes (cont.)

- Procedural
 - Closely monitor Quality Net and protest inaccuracies timely
 - Docket when data are expected for review, or when charts are expected to be uploaded to Quality Net
 - Create a certification system, such that one or more individuals are responsible for verifying the accuracy of information in Quality Net
 - Protect your protest rights by sending dispute letters where data, or methodology underlying an indicator, is inaccurate or inappropriate
 - Verify when payment determinations are received, and docket appeal/reconsideration timeframe
 - Appeal claims and cost reports until CMS clearly identifies appeal procedure for HACs, Readmissions, and VBP

Avoiding Adverse Quality Data Outcomes (cont.)

- Advocacy
 - Consider what evidence you might have regarding comorbidities that CMS has given short shrift to
 - Decide whether values have topped out and CMS should be asked to remove from VBP
 - Decide whether to advocate that CMS should change its domain weightings

Description of Some of the Ways in
Which Physician Behavior Can
Influence P4P Results

Description of Some of the Ways in Which Physician Behavior Can Influence P4P Results

- Ordering of appropriate drugs, such as fibrinolytic therapy, antibiotics, and beta blockers, during the specified times results in positive quality indicator scoring
- Creating appropriate discharge plans reduces risk of 30 day mortality and readmissions, and appropriate follow-up after discharge could be critical, including, potentially, visiting the patient at home
- Ability of physician to communicate effectively with patient and to control pain are aspects of the HCAHPS survey

Program Integrity Implications of
Incentives to Physicians to Support
P4P Efforts

Program Integrity Implications of Incentives to Physicians to Support P4P Efforts

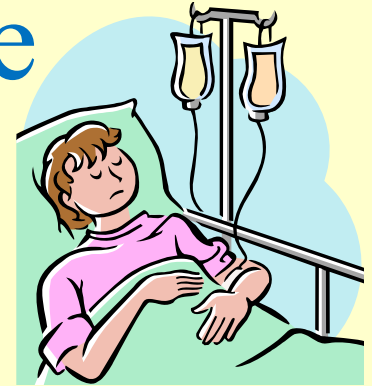
- Very similar issues to co-management agreements – what is the hospital allowed to pay for without violating the Anti-Kickback Statute or Stark?
- Different rules apply for hospitals that employ physicians, versus those with a purely voluntary medical staff
 - For employees, may be able to take advantage of Anti-Kickback Statute employee safe harbor and Stark employee exception
 - For voluntary medical staff, may be able to take advantage of the Anti-Kickback Statute employee safe harbor and Stark employee exception
- Most challenging areas from a legal risk perspective will be defining the types of services that a physician will be furnishing and determining the fair market value for those services

Cowboys and Pit Crews

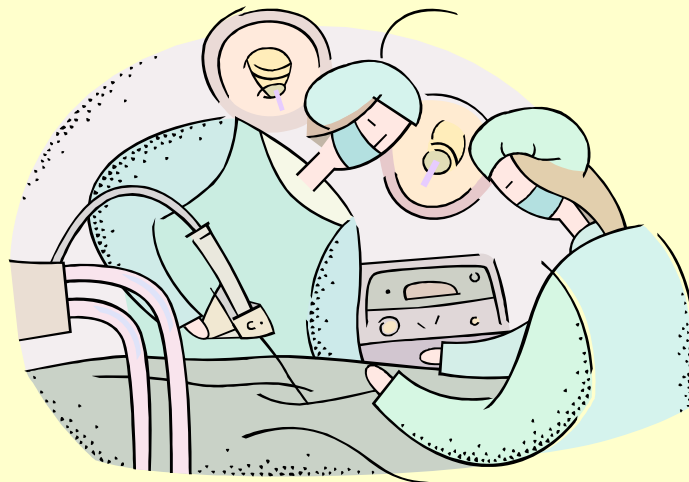


The New Yorker, May 26, 2011
AtulGawande

The Pit Crew Challenge



BUILD AN EFFECTIVE TEAM



Building a “Health Care” Pit Crew

- Involve Board of Trustees/Directors
- Focus on Appropriate Care Measures
 - how often hospital provided “optimal” care for a patient with a given clinical condition
- Report Results
- Establish Quality Culture



Recruit Physician Champions

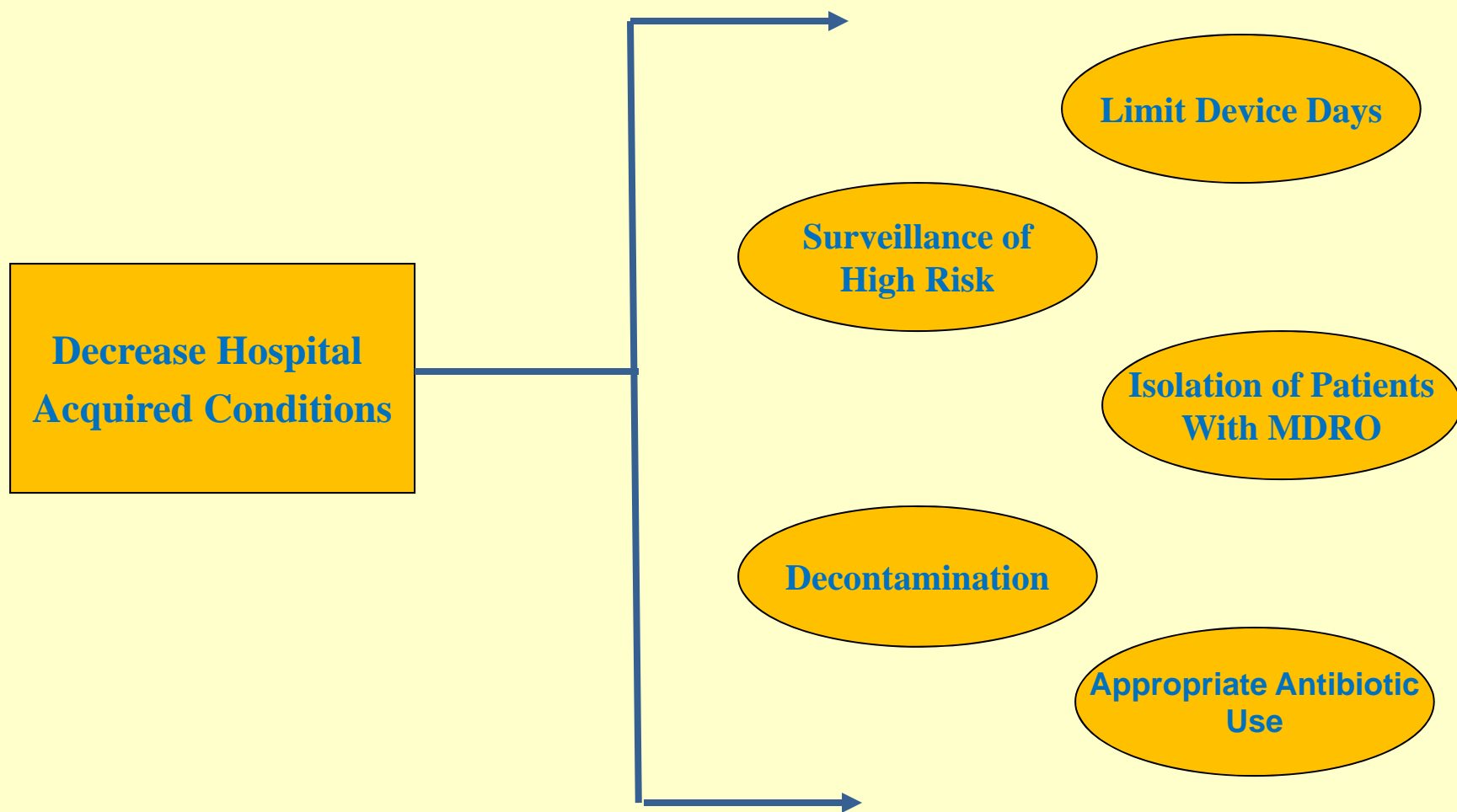
- Educate
- Share Data
- Rely Upon Established Programs – Peer Review
- Communicate, Communicate, Communicate
- Focus on New Physicians
- Achieve Physician Buy-In



Hospital Acquired Conditions

Global Aim

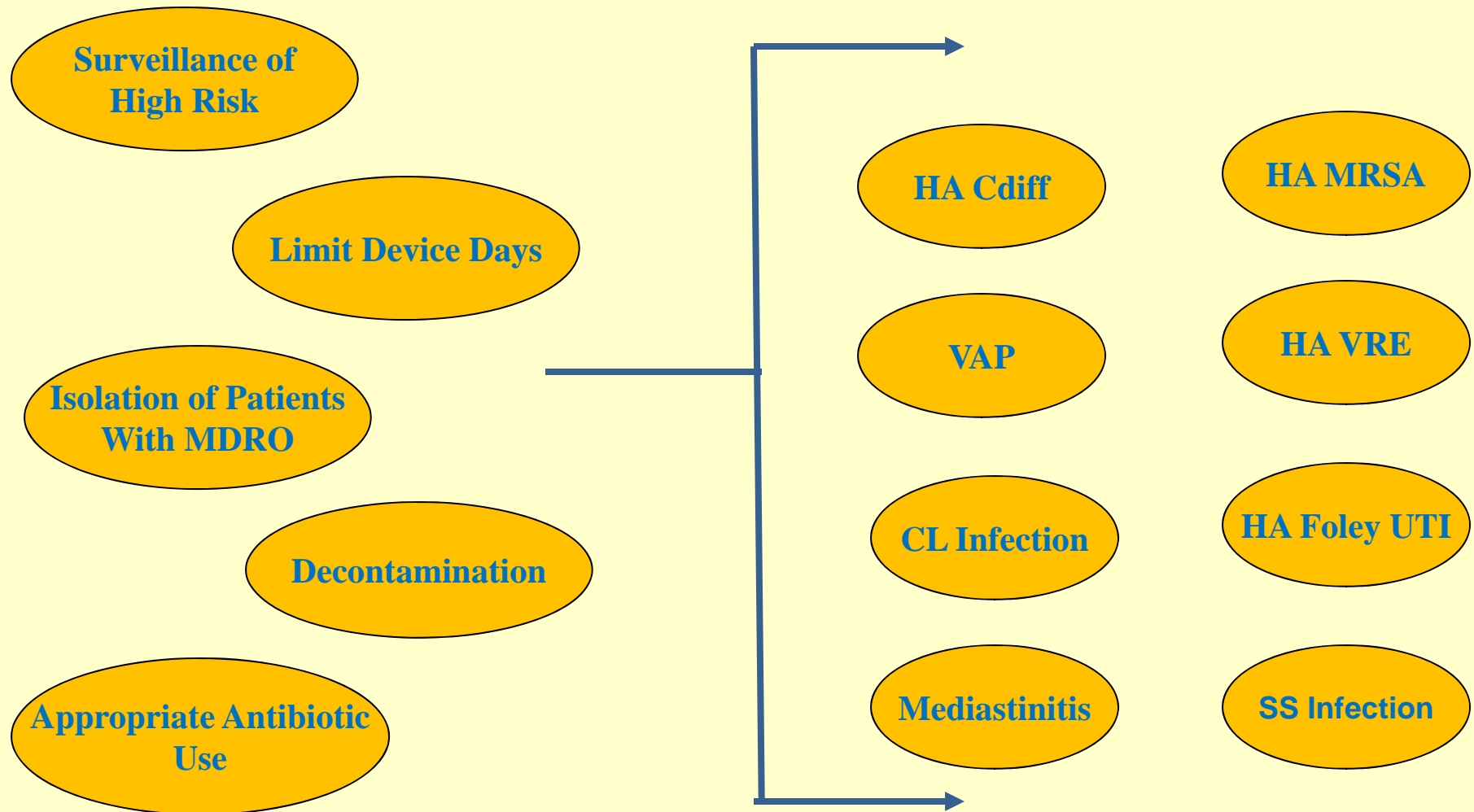
Primary Drivers



Hospital Acquired Conditions

Primary Drivers

HAC Examples



Reduce Readmissions

- Review Rates by Service Line
- Establish Collaborative Teams to Address
- Transition Care

Value Based Purchasing – Surgical Site Infection

- Focus on Best Practices
- Review All Causes of Infection
 - Skin
 - Antibiotics (best practice, not regulatory)
 - Operating Rooms
 - Post Op Care
 - Care of Wound
 - Discharge

Questions?