

VALUE BASED PURCHASING

“TO INFINITY, AND BEYOND...”

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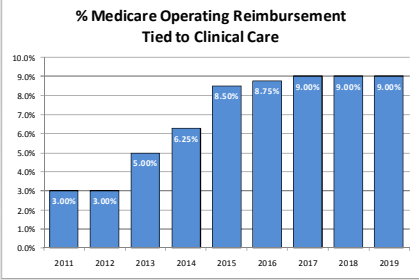
CMS: Value-Based Purchasing*

(in Support of Triple Aim: Better Health, Care, and Cost)

Federal Fiscal Year

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Hospital Value-Based Purchasing (1-2%; Phased in over 4 Years)			1.00%	1.25%	1.50%	1.75%	2.00%		
Hospital Readmissions (1-3%; Phased in over 3 Years)			1.00%	2.00%	3.00%				
Hospital Acquired Conditions (1%)					1.00%				
EHR Meaningful Use (3%)		3.00%							

Incremental phase-in of reimbursement changes by program



% Medicare Operating Reimbursement Tied to Clinical Care

Incremental phase-in of reimbursement changes by year

* Initially Medicare, but law requires extension to Medicaid

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VALUE BASED PURCHASING

- Why are we having this conversation?
 - Bending the Cost Curve
- What are the rules?
- Where do we focus?
- How do we succeed?

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CMS' VALUE BASED PURCHASING INITIATIVE

Medicare' s fee-for-service schedules and prospective payment systems based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided

Transforming Medicare from passive payer to active purchaser

Payment policy can encourage higher quality and avoidance of unnecessary costs to enhance the value of care

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DRIVERS OF UTILIZATION

- Number of hospital beds
 - More beds = higher # admits/1000 patients
 - Longer length of stay
- Number of physicians
 - More frequent visits for same condition
- Ratio of primary care to specialist
 - More diagnostic testing
 - More physician procedures
- Physicians and Hospitals have financial incentives to do more

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MEDPAC RATINGS

- Compares Medicare services delivered by metropolitan service area (MSA)
- Only measures services provided in the MSA to beneficiaries who live within the MSA
- Is corrected for age and severity
- Compares services delivered not cost
- Higher use of services does not equal better outcomes
- 100 represents the median of US MSA

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A TALE OF TWO CITIES

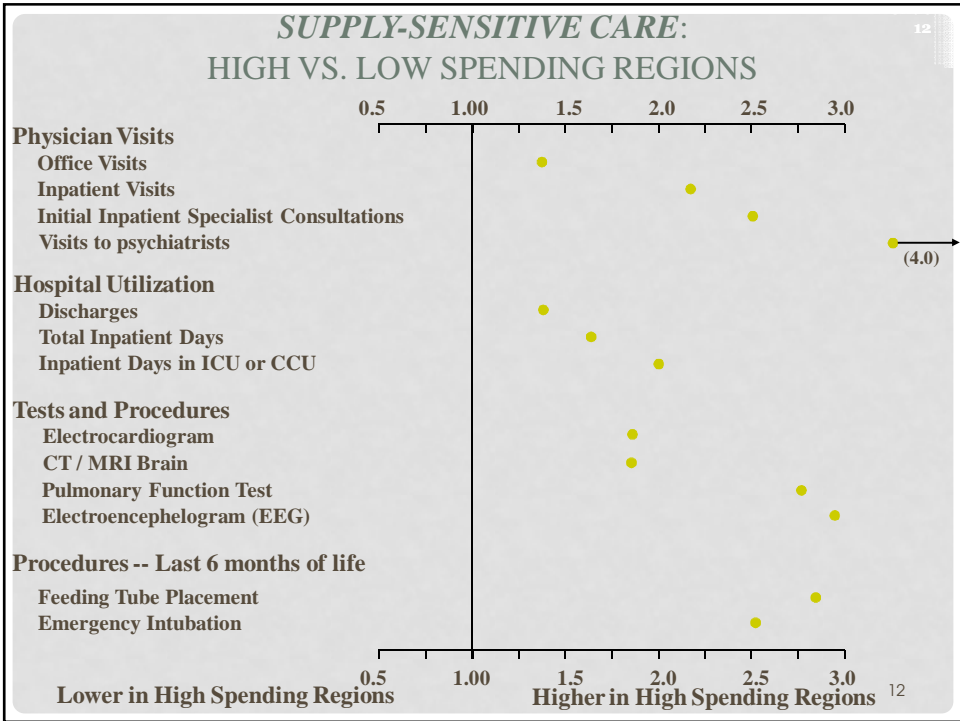
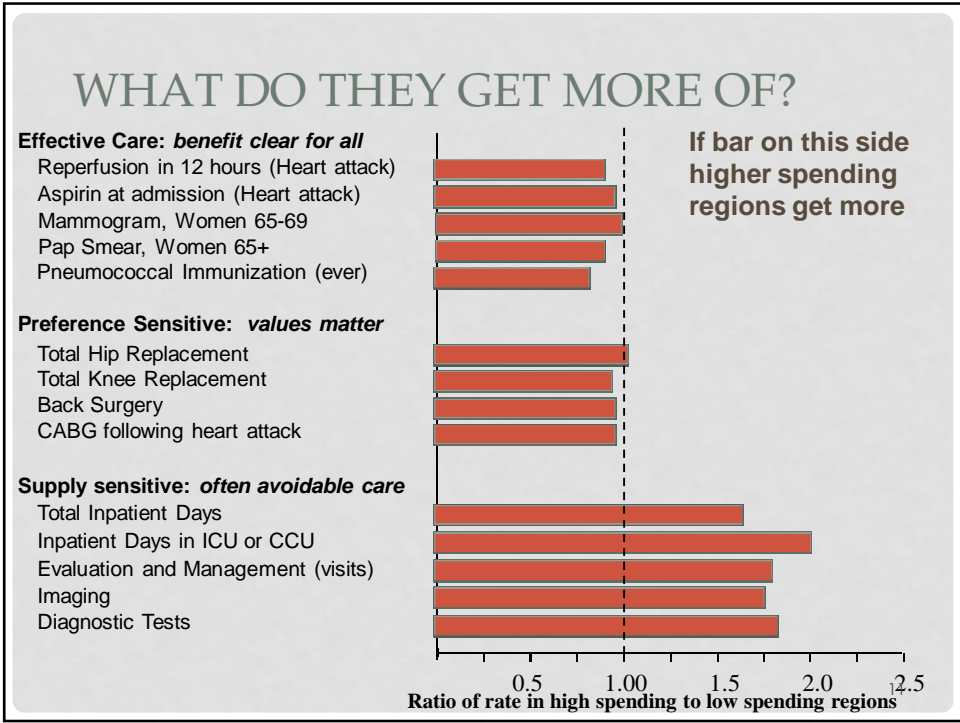
- | | |
|---|---|
| • City A, Texas | • City B, Texas |
| • Population 220,000 | • Population 100,000 |
| • Pop. served 1.2 million | • Pop. served .5 million |
| • Physicians > 800 | • Physicians 200 |
| • Primary/ specialist 1/3 | • Primary/ specialist 1/1 |
| • Employed vs total MD on med staff 120/600 | • Employed vs total MD on med staff 120/187 |
| • MD owned facility-many | • MD owned facility-none |
| • Beds 30% excess | • Beds ?? |
| • MedPAC score 123 | • MedPAC score 103 |

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THE PARADOX OF PLENTY HIGH SPENDING COMPARED TO LOW SPENDING REGIONS

Health Outcomes	Physician's Perceptions	Patient-Perceived Quality
No gain in survival	Worse communication	Lower satisfaction with hospital care
No better function	Greater difficulty ensuring coordination	Worse access to primary care
	Greater perception of scarcity	No less sense that care is rationed

(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
 (2) Baicker et al. Health Affairs web exclusives, October 7, 2004
 (3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
 (4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
 (5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
 (6) Fowler et al. JAMA: 299: 2406-2412

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VALUE BASED PURCHASING

- Established by Affordable Care Act (ACA) of 2010.
- Implementation CMS in FFY 2013.
- Three quality domains:
 - Clinical Process of Care (12 core measures)
 - Patients' Experience of Care (HCAHPS Survey 8 indicators)
 - Outcomes (30-day mortality for AMI, heart failure and pneumonia, 8 Hospital-Acquired Conditions, and 2 AHRQ patient safety measures) [delay until 2014](#).

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COMPONENTS OF THE RULE

- **Score Calculation**
 - the higher of achievement or improvement points for a measure
- **Redistribution of Residual Funds**
 - all monies in the VBP incentive pool must be paid out during the same period
- **Topped Out Measures**
 - 12 measures rather than the CMS 19
 - Excluded if 75% and 90% are statistically the same

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SCORE CALCULATION DESCRIPTION

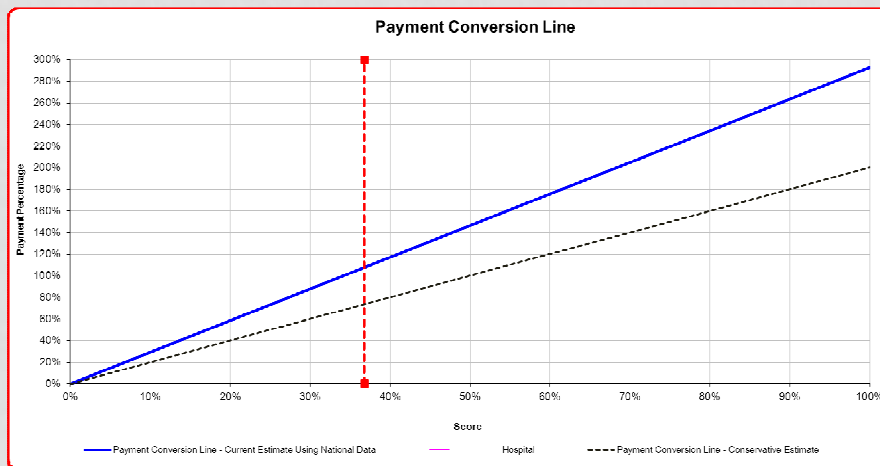
- **Calculating Achievement Points**
- **Achievement Threshold** (median for all hospitals) for each measure.
 - below the achievement threshold, the hospital will receive **0** achievement points.
 - between the threshold and national benchmark, it will receive between **1 and 9** points
- **National Benchmark** (average score for top 10%)
 - at or above benchmark receives **10** points

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CALCULATING AN OVERALL VBP SCORE

- 70% of the total Process of Care Domain score
- 30% of the total Patients' Experience of Care Domain score.
- Final score is plotted on a payment line calculated to disburse 100% of the withhold
- The challenge is that everyone is getting better!

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Hospital
Analysis of the FFY 2013 Medicare Hospital VBP Final Rule
Payment Impact Estimates
 Performance Period: October 1, 2009 - September 30, 2010

Process Domain Score: 41.82% HCAHPS Domain Score: 25.00% VBP Total Performance Score: 36.77%		FFY 2013 VBP Program Impact Analysis	
CURRENT ESTIMATE (using most recent data from Hospital Compare)		<i>Estimated Payment from VBP</i>	
VBP Payment Percentage: 107.70%		\$209,000	
Net VBP Gain		\$14,900	
CONSERVATIVE ESTIMATE (assumes scores improve nationally from currently available data)		<i>Estimated Payment from VBP</i>	
VBP Payment Percentage: 73.55%		\$142,800	
		Net VBP Loss	
		(\$51,300)	

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NEW RULES! 2014

Measure ID	Measure	National Threshold	National Benchmark
Process of Care Domain (newly proposed)			
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 Anti-biotic 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
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

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NEW RULES! 2014

Patient Experience of Care Domain (newly proposed)			
HCAHPS Dimension	Communication with Nurses	75.79%	84.99%
	Communication with Doctors	79.57%	88.45%
	Responsiveness of Hospital Staff	62.21%	78.08%
	Pain Management	68.99%	77.92%
	Communication about Medicines	59.85%	71.54%
	Hospital Cleanliness & Quietness	63.54%	78.10%
	Discharge Information	82.72%	89.24%
	Overall Rating of Hospital	67.33%	82.55%

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NEW RULES! 2014

Patient Outcomes Domain (previously adopted and newly proposed)			
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate (shown as survival rate)	0.8477	0.8673
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate (shown as survival rate)	0.8861	0.9042
MORT-30 PN	Pneumonia (PN) 30-Day Mortality Rate (shown as survival rate)	0.8818	0.9021
HACs *	HACs per 1,000 (aggregated)	0.00109	0.0000
AHRQ Composite	Complication/patient safety for selected indicators (composite)	0.4006	0.2754
AHRQ Composite	Mortality for selected medical conditions (composite)	0.7542	0.6130
Efficiency Domain (previously proposed)			
Efficiency Measure	Medicare Spending per Beneficiary (calculated as a ratio of the Medicare spending per beneficiary amount for each hospital to the median Medicare spending per beneficiary amount across all hospitals)	1.0 (median Medicare spending per beneficiary ratio across all hospitals during the performance period)	Mean of the lowest decile of Medicare spending during the performance period

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NEW RULES! 2014

- Clinical process of care: **45%**
(set at 70% for the FFY 2013 program)
- Patient experience of care: 30%
(set at 30% for the FFY 2013 program)
- Patient outcomes: **25% (only mortality)**
- Efficiency: **deferred**

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HOSPITAL ACQUIRED CONDITIONS

	Never Events			Infection-Related Events		Patient Safety Events		
HAC	Blood Transfusion Reactions	Air Embolism	Retained Foreign Bodies	CA-UTI	VCA-BSI	Glycemic Control	Falls & Trauma	Pressure Ulcers
Defined	Giving the wrong blood type to a patient	Air bubble in the blood stream	Objects (sponges, instruments) accidentally left in the body after surgery	Urinary tract infection related to a urinary catheter	Infection related to vascular catheter (IV)	Signs of uncontrolled blood sugar levels	Bone fracture, dislocation, intracranial injury, crushing injury, burn or electric shock	Severe pressure sores (Stages III & IV)

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MEDICARE READMISSION

- Acute care hospitals with higher than expected 30-day risk-adjusted readmission rates will receive reduced Medicare payments for **every** discharge.
- Payment will be reduced by the **lower** of a hospital-specific readmissions adjustment factor or a pre-determined maximum (1% 2013, 2% 2014, 3% 2015)
- heart failure, heart attack, and pneumonia
- program will expand to additional conditions in year three and thereafter.

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HEALTH CARE REFORM: PHYSICIAN VALUE-BASED PAYMENT MODIFIER

Intended to decrease payments to physicians with high Medicare costs unless measured quality is equally high (and vice versa)

- CMS proposed measures and rules – 2012
- Implement for some physicians – 2015, for all in 2017
- Budget-neutral so winners and losers

Data Source: HAC Reduction Program, Patient Protection and Affordable Care Act (PPACA), 2010

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DOCUMENTATION CONSIDERATIONS

- Timely Documentation
 - Early identification - Present on Admission
- Complete Documentation
 - Ruled In versus Ruled Out – After Study
 - Contamination
 - Continued treatment and documentation of disease process
 - Discontinued treatment and no longer documenting disease process
 - Signs and Symptoms versus Definitive Diagnosis
- Accurate Documentation
 - Conflicting documentation between multiple physicians within the record

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CRITICAL SUCCESS FACTORS

- Value Based Purchasing
 - Embrace the Evidence
 - Patient centered service excellence
 - Standardize when appropriate
 - Follow the data
- HAC
 - Target is ZERO
 - Document clearly
- Lead to Culture of Safety
- Demand Data
- Become a Learning Organization

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WHAT WILL HOSPITALS DO?

- increase focus on patient experience and patient satisfaction
- increase communication at the time of discharge with patients and physicians
- work with physicians to develop better alternatives to the ED for patients without access to primary care
- continue to focus on physician documentation since all of these programs are based on administrative data
- increase deployment of the electronic health record
- increase engagement with physicians to find **creative ways to improve the outcomes of care**
- increase desire to integrate more closely with physicians related to **quality and efficiency...think throughput**
- Focus on the continuum...**breaking down silos**

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WHAT MUST ALL OF US DO?

- Actually be a system
- Provide care that "fits" the patient
- Demonstrate that we deliver the best possible care
- Care is provided at the appropriate cost

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THE CHALLENGE...

If you want to go quickly...go alone.

If you want to go far...go together.

African proverb

We must go far...quickly!

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Questions?

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