


**American Hospital
Association**

Linking Payment to Performance

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Reform: What Will It Be?

- Familiar in part, but different – and sometimes confusing
- Unclear how the parts will work together



Quality/ Safety Related Provisions

Resetting the Framework

- National Quality Strategy
- Center for Innovation
- Minority Health and Reducing Disparities
- Patient Safety Research
- Medicare data Availability
- Comparative Effectiveness Research


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Quality/ Safety Related Provisions

Fundamental Incentive Changes

- IPAB
- Hospital VBP
- Physician Care Transparency and VBP
- Pilot for bundled pay
- Accountable Care Organizations
- Quality Reporting for Post Acute care
- Medicaid Global Payment demos



Quality/ Safety Related Provisions

Changes To Familiar Systems

- Hospital Readmissions
- Hospital Acquired Conditions
- Physician Value Modifier



Quality/ Safety Related Provisions

Other Provisions of Interest

- Health Homes for Medicaid Patients with Chronic Conditions
- Community Based Care Transitions
- Physician Quality Reporting System
- Independence at Home Program
- Patient Navigator Program
- Educating Health Professionals on QI
- Requiring PSOs

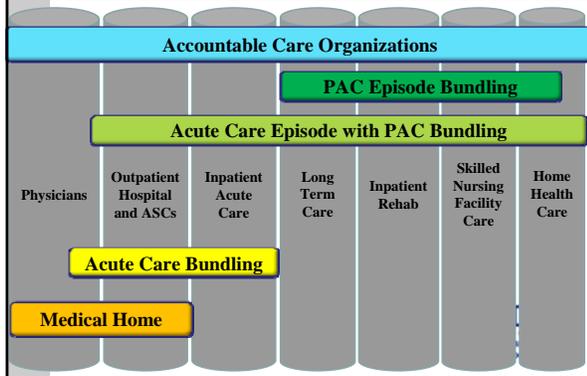


Focus For Today

- National Quality Strategy
- Hospital VBP
- Accountable Care Organizations
- Bundled Pay Pilots
- Hospital Readmissions
- Hospital Acquired Conditions
- Center for Innovation



Models of Service Delivery



Options for Achieving Greater Continuity



Reform Requires Infrastructure

At the Organization Level

- Unifying goals and objectives
- Systems and processes for working together
 - Shared data
 - Shared understanding of the science of care
 - A plan for change that allows survival during transition
- Communication structures that enable work (e.g., information technology)



Reform Requires Infrastructure

At the State/Local Level

- Unifying goals and objectives linking payment and policy to quality
- Systems and processes for providers to learn what works
 - Patient Safety Organizations
 - Collaborative improvement activities
- Information technologies for critical information sharing



Reform Requires Infrastructure

At the National Level

- Common goals and objectives that unite providers, payers, policymakers actions
- Systems and processes for aligning policies
- Communication structures that enable critical data collection
- Elimination of regulatory barriers



Barriers Exist

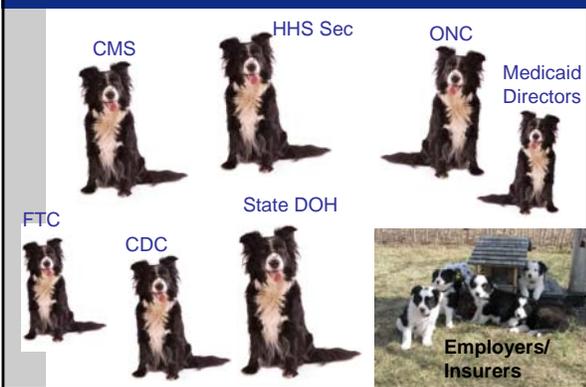
- Data protections
- Outdated Conditions of Participation & accreditation standards
- Payment policies at all levels
- Legal hurdles: Antitrust, Self referral (Stark), Civil monetary penalties, Anti-kickback, Internal Revenue Code



Change Requires



Current Situation....





- ### National Quality Strategy
- First report due to Congress January 2011
 - At least 5 acute and 5 chronic conditions
 - Provider level measures
 - Updates every three years
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- ### ACOs Per Affordable Care Act
- An ACO Will:**
- Manage and coordinate care for Medicare FFS patients and meet quality standards to be established by the Secretary
 - Be able to receive and distribute shared savings
 - Begin January 1, 2012
- 

ACOs Per Affordable Care Act

- Shall be willing to become accountable for the quality, cost and overall care of Medicare FFS beneficiaries assigned to it
- Shall participate for not less than 3 years
- Shall have a formal legal structure for handling shared savings
- Shall have not less than 5000 beneficiaries assigned and sufficient primary care professionals



ACOs Per Affordable Care Act

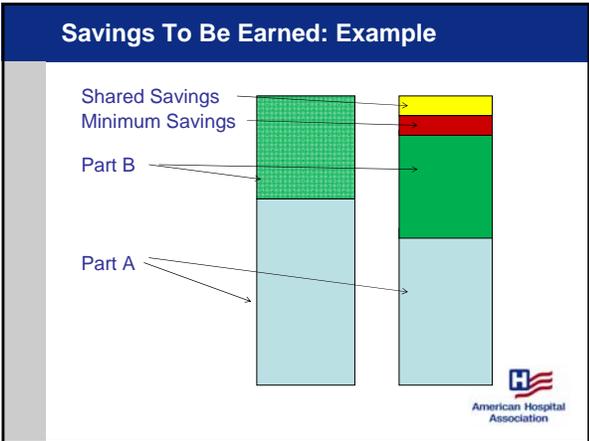
- Have leadership and management structure in place with clinical and administrative systems to:
 - Promote evidence-based medicine and patient engagement
 - Report on cost and quality
 - Coordinate care
 - Be able to demonstrate patient-centered care



ACO Example (cont)

- Assignment of patients
 - Based on primary care use
 - No ability to require patients to use specific providers
 - Penalties for attempts to avoid “at risk” patients
- Savings
 - Eligible only if total Part A and B costs per capita are some percentage less than they otherwise would have been and quality meets or exceeds benchmark
 - Organization receives a portion of the savings





Bundled Payment Per PPACA

- Beginning in 2013, a national voluntary pilot
 - Pilot runs for 5 years
 - Secretary may choose to extend
- Eligible organizations:
 - Hospital + physician group + SNF + Home Health
- Must use tool to assess proper Post Acute placement of patients

Bundled Payment Per PPACA

- Must submit quality data:
 - functional status, avoidable readmissions, discharge to community, return to ER, infections, patient-centeredness, patient perception, outcomes and efficiency
- 10 conditions selected by Secretary
 - Chronic and acute
 - Surgical and medical

Bundled Payment Per PPACA

- Episode is 3 days prior and 30 days post admission
- Must test various payment methods (e.g., calculated rates, bids)
- Must test Continuing Care Hospital model



Bundled Payment Per PPACA

Open Questions:

- What surgical and medical care episodes are best suited to bundling?
- What happens if the patient needs care beyond 30 days?
- If patient has co-morbid conditions, is the needed care in the payment bundle?



Bundled Payment Per PPACA

Open Questions:

- What determines whether the providers will be paid the bundled amount or FFS/ Inpatient payments?
- What if the patient wants an “out of bundle” provider?
- What happens if the science surrounding care of patients shifts? Will payments be renegotiated?



The Changing Financial Perspective		
	Current System	Reformed Perspective
Unneeded Services	Revenue producer	Drain on resources
Care Coordination	Drain on resources	Investment to generate savings
Medical Errors	Drain on resources	Drain on resources and potential penalty
Readmissions	Source of cost and revenue	Source of cost and potential penalties

Value Based Purchasing

- A long time in coming --- and still waiting until 2013
- Meant to allow providers to do well by doing the right things for patients
- Still built around the inpatient silo of care



Value Base Purchasing for Hospitals

- CMS' 2007 Report to Congress laid the foundation
- Use publicly reported quality measures
- Add efficiency and outcomes
- Exclude readmissions
- Reward improvement and achievement



Value Base Purchasing for Hospitals

Challenges:

- Small numbers
- Not all measures are equal
- Physician incentives not aligned
- Provides a financial incentive for not sharing improvement strategies



Readmissions

- Beginning in FY 2013
- Readmission rates that are “higher than expected” (observed vs expected ratio) will be penalized
 - Start with AMI, HF, PNE
 - Secretary can add more starting in 2015



Readmissions

- Penalty for excess readmissions for any condition :
AVERAGE COST PER CASE (for that diagnosis)
x NUMBER OF READMISSIONS
- Total penalty:
AMI penalty + HF penalty + PNE
penalty (not to exceed 1% in 2013, 2% in 2014 or 3% thereafter)



Hospital Acquired Conditions

- Beginning in 2015
- For Hospital Acquired Conditions selected by the Secretary (infections, falls, etc)
- Rate of HACs calculated for all hospitals
- Hospitals ranked high to low
- Top 25% penalized 1% of payment for all Medicare discharges

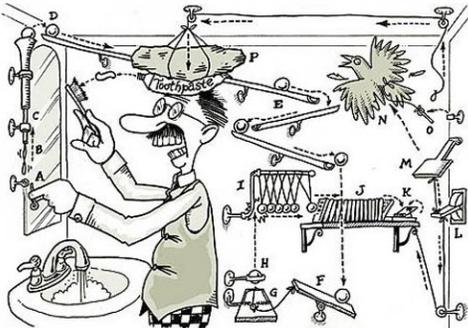


Hospital Acquired Conditions

- Risk adjustment method must be developed
- Rates must be shared confidentially with hospitals prior to 2015
- Rates will be published on Hospital Compare
- Medicaid programs must adopt policies on HACs



Reform: What Is It?



Thank You

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