HEALTHCARE REFORM...WHERE CAN PHARMACY HELP?

TUESDAY, AUGUST 11:
WELCOME

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Vice President, Professional Affairs
Iowa Pharmacy Association
Healthcare Reform.. Where can pharmacy help?

Monica Barrington, RPh, MPH, FASCP
Vice President, Engagement and Delivery
Premier, Inc.
Our Mission: To improve the health of communities.

- Uniting approximately 3,400 hospitals – 68% of U.S. community hospitals – and 110,000 alternate sites of care
- 74% owned by health systems
- $41 billion in group purchasing volume
- Integrating clinical, financial, operational and population data
- Insights into ~ 1 in every 3 U.S. hospital discharges

MAKE HEALTHCARE SUPPLY CHAIN EFFICIENT AND EFFECTIVE
DEVELOP CONTINUOUS IMPROVEMENT IN COST AND QUALITY TODAY AND ENABLE SUCCESS IN NEW HEALTHCARE DELIVERY / PAYMENT MODELS
INTEGRATE DATA AND KNOWLEDGE TO CREATE MEANINGFUL BUSINESS INTELLIGENCE THAT DRIVES IMPROVEMENT
Today’s presentation

- Political environment and implications
- Proposed HCR changes and direction
- What are the areas that you should be attentive to as the nation moves toward population health?
Historic Republican Majority: Implications

Motivations

• “Party of No”

• Senate realities:
  » 54 seats provides Majority leader flexibility
  » But many Senators running for Presidency
  » 60 votes needed for cloture; 67 to overcome veto
  » Bipartisanship essential for Republicans
  » Democrats well positioned in 2016 Senate races
    ▪ 2014: Defending 23 seats v. Republican 11
    ▪ 2016: Defending 10 seats v. Republicans 23 seats
  » Senate Democrats not inclined to cooperate

• House Realities:
  » Largest majority since 1928
  » Provides Speaker governing flexibility
  » Republican majority until redistricting (2020)
  » House strategy to “jam” the Senate
Historic Republican Majority: Implications

**Motivations**

**Healthcare spending** dominant policy concern

**WHAT’S DRIVING THE DEBT**
(Spending and Revenue as a Percentage of GDP)

- Net Interest
- Social Security
- Medicare
- Medicaid & Other Health
- Tax Revenues (% GDP)

Source: CBO

© 2015 PREMIER INC.
Accumulating hospital cuts

Impact of Hospital Cuts Since FY 2010

- Affordable Care Act ($155B)
- Sequestration ($58.3B)
- MS-DRG ($50.4B)
- Medicaid DSH (16.6B)
- 3-Day Window ($4.2B)
- Bad Debt ($2.1B)
- 2-Midnight Offset ($2.4B)

Total cuts: $289B
Hospital Margins

- Hospital fiscal years beginning in July 1, 2012 through June 30, 2013
- Number of hospitals (outliers excluded): 3,086
- Average Inpatient Medicare Margin: -7.3%
- Average Overall Medicare margin: -9.4%
- Average All Payer Margin: 4.8% (positive)
In three words, our vision for improving health delivery is about **better, smarter, healthier**.

If we find better ways to pay providers, deliver care, and distribute information:

- We can receive better care.
- We can spend our health dollars more wisely.
- We can have healthier communities, a healthier economy, and a healthier country.

### Focus Areas

**Incentives**

- Promote value-based payment systems
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

**Care Delivery**

- Encourage the integration and coordination of clinical care services
- Improve population health
- Promote patient engagement through shared decision making

**Information**

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

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Source: CMS
Choice of Payment Models through ACA
FFS payments linked to quality and alternative payment models

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 30% in Alternative payment models
- 85% in All Medicare FFS

2018
- 50% in Alternative payment models
- 90% in All Medicare FFS

Source: CMS
### ACA: Value-based Purchasing across payment silos

#### Traditional Payment Models

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician</strong></td>
<td><strong>Accountable Care Organizations</strong></td>
</tr>
<tr>
<td>RBRVS</td>
<td><strong>Acute and Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td><strong>Outpatient Hospital and ASCs</strong></td>
<td><strong>Acute Care Bundling</strong></td>
</tr>
<tr>
<td>APC</td>
<td><strong>Medical Home</strong></td>
</tr>
</tbody>
</table>

#### Alternative Payment Models

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Acute Care</strong></td>
<td><strong>Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td>MS-DRG</td>
<td><strong>Acute and Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td>VBP commenced 10/1/12</td>
<td><strong>Acute Care Bundling</strong></td>
</tr>
<tr>
<td><strong>Long Term Acute Care</strong></td>
<td><strong>Medical Home</strong></td>
</tr>
<tr>
<td>MS-DRG</td>
<td><strong>Accountable Care Organizations</strong></td>
</tr>
<tr>
<td>P4R in FY14: VBP test pilot by 1/1/16</td>
<td><strong>Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td><strong>Inpatient Rehab</strong></td>
<td><strong>Acute and Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td>RICs</td>
<td><strong>Acute Care Bundling</strong></td>
</tr>
<tr>
<td>VBP test pilot by 1/1/16</td>
<td><strong>Medical Home</strong></td>
</tr>
<tr>
<td><strong>SNFs</strong></td>
<td>VBP starting 10/1/19</td>
</tr>
<tr>
<td>RUGs</td>
<td><strong>Accountable Care Organizations</strong></td>
</tr>
<tr>
<td>VBP starting 10/1/19</td>
<td><strong>Post-Acute Care Episode Bundling</strong></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td><strong>Accountable Care Organizations</strong></td>
</tr>
<tr>
<td>HHRGs</td>
<td><strong>Post-Acute Care Episode Bundling</strong></td>
</tr>
</tbody>
</table>

- Value modifier implemented in FY2013 PFS. MIPS in 2019.
- P4R in FY2013; ASC VBP impl. plan submitted to Congress on 4/18/11
- VBP commenced 10/1/12
- P4R in FY14: VBP test pilot by 1/1/16
- VBP test pilot by 1/1/16
- VBP commencing 10/1/19
- VBP impl. plan sent to Congress 3/12. CMS proposes 2016 start
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Proposed HCR changes and direction
PHYSICIANS AND PROVIDERS
Medicare Access and CHIP Reauthorization Act of 2015

Created in 1997, the SGR capped Medicare physician spending per beneficiary at the growth in GDP

The formula does not incentivize high-quality, high-value care

Since 2003, Congress has passed 17 laws to override SGR cuts

SGR creates uncertainty and disruption for physicians and other providers

Most of $170B in ‘patches’ financed by health systems

On 3/26, the House passed H.R. 2 by 392-37 vote.

On 4/14, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.
Current Law and SGR reform timeline

- **Physician Quality Reporting System Penalty**
  - 2015: -1.5%
  - 2016 & beyond: -2.0%

- **Meaningful Use Penalty (up to %)**
  - 2015: -1.0%
  - 2016: -2.0%
  - 2017: -3.0%
  - 2018 & beyond: -4.0%
  - 2019 & beyond: -5.0%

- **Value-based Payment Modifier penalty (up to %)**
  - 2015: -1.0%
  - 2016: -2.0%
  - 2017: -4.0%
  - 2018 & beyond: ???%

- **Sunset of existing quality value penalties under PQRS, VBM, EHR**
  - 12/31/2018

- **Permanent repeal of SGR**
  - 12/31/2018

- **Updates in physician payments**
  - 0.5% (7/2015-2019)
  - 0% (2020-2025)
  - 0.25% (2026)

- **Merit-Based Incentive Payment System (MIPS) adjustments**
  - 2019: +/- 4%
  - 2020: +/- 5%
  - 2021: +/- 7%
  - 2022 & beyond: +/- 9%
  - MIPS exceptional performance adjustment; Up to 10% annually (2019-2024)

- **APM participating providers exempt from MIPS; receive annual 5% bonus (2019-2024)**
  - 0.75% update (2026)
Merit-Based Incentive Payment System (MIPS) weighting

PQRS, MU, and VM will combine into a single payment adjustment under MIPS in 2019.

- **Quality**—Physician Quality Reporting System measures.
- **Resource use**—Value-based Payment Modifier measures.
- **Meaningful Use of EHR**—EHR incentive payment measures.

**CY 2019**
- Quality: 50%
- Resource use: 15%
- Meaningful Use of EHR: 15%
- Resource use: 25%

**CY 2020**
- Quality: 45%
- Resource use: 15%
- Meaningful Use of EHR: 15%
- Resource use: 25%

**CY 2021**
- Quality: 30%
- Resource use: 15%
- Meaningful Use of EHR: 15%
- Resource use: 30%
First update in 14 years for LTC conditions of participation

Proposed changes:

• Improve staff training on patient’ centered care
• Decisions on composition and level of staff
• Improving care planning, to include discharge
• Give dieticians and therapy providers authority to write orders where allowed
• Requiring better food choices
• Update of infection prevention and control programs
• Antibiotic stewardship program to include antibiotic use protocols and system for monitoring antibiotic use
Proposals for measures currently in use for LTCH QRP

- Requesting comments for adopting the NQF endorsed version of All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from LTCHs (NQF #2512)

- To meet the IMPACT ACT of 2014 requirements
  - Propose to change the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) to a cross-setting measure for skin integrity and changes in skin integrity domain
  - Propose to change Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) to a cross-setting quality measure for incidence of major falls domain

Proposals for new measures for 2018 payment

- To meet the IMPACT ACT of 2014 requirements
  - Use an application of the Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
    - Addresses Functional Status, Cognitive Function, and Changes in Function and Cognitive Function domain
    - Collect via LTCH CARE Data Set
CMS is requesting comment on importance, relevance, appropriateness, and applicability of each of the quality measures and quality measure concepts.

### Possible Future LTCH QRP Measures for Future Years

<table>
<thead>
<tr>
<th>National Quality Strategy (NQS) Priority: Patient Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Weaning (Liberation) Rate</td>
</tr>
<tr>
<td>Compliance with ventilator process Elements during LTCH Stay</td>
</tr>
<tr>
<td>Venous Thromboembolism Prophylaxis</td>
</tr>
<tr>
<td>Medication Reconciliation*</td>
</tr>
</tbody>
</table>

**NQS Priority: Effective Communication and Coordination of Care**

<table>
<thead>
<tr>
<th>Transfer of health information and care preferences when an individual transitions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Rate*</td>
</tr>
</tbody>
</table>

**NQS Priority: Patient- and Caregiver-Centered Care**

<table>
<thead>
<tr>
<th>Discharge to community*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience of Care</td>
</tr>
<tr>
<td>Percent of Patients with Moderate to Severe Pain</td>
</tr>
<tr>
<td>Advance Care Plan</td>
</tr>
</tbody>
</table>

**NQS Priority: Affordable Care**

<table>
<thead>
<tr>
<th>Medicare Spending per Beneficiary*</th>
</tr>
</thead>
</table>

* Indicates that this is a cross-setting measure domain listed in the IMPACT Act of 2014.
## HOSPITAL INPATIENT QUALITY REPORTING PROGRAM
### 2016 Data Collection Summary

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>CY 2015 Count</th>
<th>Proposed Change</th>
<th>CY 2016 Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart-Abstracted</td>
<td>17*</td>
<td>Remove 9 chart abstracted</td>
<td>8</td>
</tr>
<tr>
<td>eCQMs</td>
<td>Voluntary (16)</td>
<td>Require 16</td>
<td>16</td>
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<tr>
<td>HAI / NHSN</td>
<td>6</td>
<td>No change</td>
<td>6</td>
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<tr>
<td>30 day Mortality</td>
<td>6</td>
<td>No change</td>
<td>6</td>
</tr>
<tr>
<td>30 day Readmission</td>
<td>8</td>
<td>No change</td>
<td>8</td>
</tr>
<tr>
<td>AHRQ</td>
<td>2</td>
<td>No change</td>
<td>2</td>
</tr>
<tr>
<td>Hip/Knee Complications</td>
<td>1</td>
<td>No change</td>
<td>1</td>
</tr>
<tr>
<td>Efficiency</td>
<td>4</td>
<td>Add 7</td>
<td>11</td>
</tr>
<tr>
<td>Structural</td>
<td>3</td>
<td>Add 1</td>
<td>4</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>1</td>
<td>No change</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>48 (64)</td>
<td></td>
<td>63</td>
</tr>
</tbody>
</table>

*includes suspended measures
Proposed New Payment/Efficiency Measures

CMS proposes to add 7 new claims-based measures

- Kidney/UTI Clinical Episode-Based Payment Measure
- Cellulitis Clinical Episode-Based Payment Measure
- Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure
- Lumbar Spine Fusion/Re-Fusion Clinical Episode-Based Payment Measure
- Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA (90 days)
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
- Excess Days in Acute Care after Hospitalization for Heart Failure
Hospital Survey on Patient Safety Culture

• Reporting on a patient safety culture survey involves providing answers to the following questions listed below. Hospitals would submit answers via a Web-based tool on the QualityNet Web site:
  » (A) Does your facility administer a detailed assessment of patient safety culture using a standardized collection protocol and structured instrument?
  » (B) What is the name of the survey that is administered?
  » (C) How frequently is the survey administered?
  » (D) Does your facility report survey results to a centralized location?
  » (E) During the most recent assessment:
    ▪ (a) How many staff members were requested to complete the survey?
    ▪ (b) How many completed surveys were received? (These questions can allow calculation of a response rate.)

• First year would start with January 1 through December 31, 2016.
  » Survey results would be reported during the annual structural measure submission schedule
Electronic Clinical Quality Measures (eCQM) Proposals for FY 2018

- Proposing to require hospitals to select and submit 16 eCQMs covering 3 NQS domains from the current 28 inpatient eCQMs

- Submit 3Q and 4Q 2016 data
  - Aligns with proposed dates for Medicare EHR Incentive Program

- Delay public reporting on Hospital Compare and provide a footnote to the measure indicating
  - the hospital submitted data via EHR;
  - data are being processed and analyzed;
  - CMS will eventually publicly report this data once CMS determines the data to be reliable and accurate.
Hospital Quality Payment Program: Still Three Predominant Programs

Last Updated February 2015

Inpatient VBP

HRRP (Readmissions)

HAC Reduction Program
Inpatient Value-Based Purchasing (VBP)

- A percent of inpatient base operating payments are at risk based on quality and efficiency metric performance
  - 1% in FY 2013
  - 1.25% in FY 2014
  - 1.5% in FY 2015
  - 1.75% in FY 2016
  - 2% in FY 2017

- A budget neutral policy, where hospitals must fail to meet targets for bonuses to be generated for others

- Rewards for achievement or improvement

- Quality measures from Hospital Compare measure set
  - 20 measures (12 process/8 HCAHPS dimensions) in FY 2013,
  - Adds 3 outcome measures (3 mortality) in FY 2014,
  - Adds 2 outcome measures and 1 efficiency measure in FY 2015,
  - Removes 5 process and adds 1 process, 2 outcome measures in FY 2016, and
  - Removes 6 process and adds 1 process, 2 “safety” measures in FY 2017

- Inpatient Quality Reporting measures are “on deck” for VBP.
Inpatient VBP: Other changes

Revision of scoring methodology for Patient and Caregiver Experience domain beginning in FY 2018

- Nine dimensions, each can receive a maximum of 10 points
- Multiply sum of points of nine dimensions by 8/9 (range 0-80 points)
- Consistency score is still out of 20 points; maximum points still 100

Changes to NHSN infection measures

- Start using new standard population data for FY 2019 baseline and performance periods
- Intent to propose using non-ICU only CAUTI and CLABSI measures beginning with program year FY 2019

New measure proposed for FY 2021 – 30-day, all-cause, risk-standardized mortality rate following Chronic Obstructive Pulmonary Disease (COPD) hospitalization

Efficiency and cost reduction domain – seeking comment on measures currently in IQR and proposed to be added to IQR for future inclusion in VBP program
Inpatient VBP
FY 2017 Domains: Align with National Quality Strategy

FY 2017 Finalized Revision

- Clinical Care
  - Process (5%)
  - Outcomes (25%)
- Patient and Caregiver Experience (25%)
- Efficiency and Cost Reduction (25%)
- Safety (20%)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>NQS-Based Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI-7a</td>
<td>Clinical Care – Process</td>
</tr>
<tr>
<td>IMM-2</td>
<td>Clinical Care – Process</td>
</tr>
<tr>
<td>PC-01 <em>NEW</em></td>
<td>Clinical Care – Process</td>
</tr>
<tr>
<td>MORT-30-AMI</td>
<td>Clinical Care – Outcomes</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Clinical Care – Outcomes</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Clinical Care – Outcomes</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>Patient and Caregiver Centered</td>
</tr>
<tr>
<td></td>
<td>Experience of Care / Care Coordination</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Safety</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Safety</td>
</tr>
<tr>
<td>MRSA <em>NEW</em></td>
<td>Safety</td>
</tr>
<tr>
<td>C. Diff <em>NEW</em></td>
<td>Safety</td>
</tr>
<tr>
<td>PSI-90</td>
<td>Safety</td>
</tr>
<tr>
<td>SSI</td>
<td>Safety</td>
</tr>
<tr>
<td>MSPB-1</td>
<td>Efficiency and Cost Reduction</td>
</tr>
</tbody>
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*FY 2017 performance periods end either June 30, 2015 or December 31, 2015.*
## Inpatient VBP FY 2018 Proposed Changes

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<td>IMM-2</td>
<td>Clinical Care—Process</td>
</tr>
<tr>
<td>PC-01</td>
<td>Safety <em>PROPOSED CHANGE</em></td>
</tr>
<tr>
<td>MORT-30-AMI</td>
<td>Clinical Care</td>
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<td>MORT-30-HF</td>
<td>Clinical Care</td>
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<td>MORT-30-PN</td>
<td>Clinical Care</td>
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<tr>
<td>HCAHPS</td>
<td>Patient and Caregiver Centered Experience of Care / Care Coordination</td>
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<td>CTM-3 <em>NEW</em></td>
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<td>CAUTI</td>
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<td>CLABSI</td>
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<td>MRSA</td>
<td>Safety</td>
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<td>Safety</td>
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</tbody>
</table>

- Clinical Care (25%)  
- Patient and Caregiver Experience (25%)  
- Efficiency and Cost Reduction (25%)  
- Safety (25%)
% Winners: 52% FY 2013, 46% FY 2014, and 55% FY 2015

Average penalty: -0.21% FY 2013, -0.25% FY 2014, and -0.29% FY 2015

Average bonus: +0.23% FY 2013, +0.23% FY 2014, and +0.44% FY 2015

Relaxed domain minimums likely led to small hospital inclusion and larger relative percent penalty/bonus
Hospital Readmission Reduction Program
Expansion of Applicable Conditions

- No expansion of conditions for FY 2016
- Expand applicable conditions to include CABG for FY 2017 (finalized in FY 2015 IPPS rule)
- Proposes to expand pneumonia cohort definition for FY 2017 payment to include patients diagnosed with:
  - Aspiration pneumonia
  - Principal diagnosis of sepsis or respiratory failure and a secondary diagnosis of pneumonia present on admission
- Impact of expanding definition: major increase to number of cases (about 65%) and the number of hospitals meeting the minimum number of cases for this measure
About 4 out of every 5 IPPS hospitals were penalized for excess readmissions in FY 2015 (greater proportion than FYs 2013 & 2014).

Slightly over 1 percent of IPPS hospitals eligible for the readmissions program received the maximum 3% penalty (8 percent received max penalty in FY 2013, less than 1 percent received max in FY 2014)

Analysis based on final readmissions payment penalty adjustment factors released in October 2014.
## Overlapping Medicare HAC policies

<table>
<thead>
<tr>
<th>Hospital-acquired conditions (HACs)</th>
<th>Not eligible higher payment (FY 08 ongoing)</th>
<th>IP VBP (FY 13 ongoing)</th>
<th>HAC Reduction Program (Starting FY 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter associated UTI</td>
<td>X</td>
<td>Finalized FY 16</td>
<td>Finalized FY 15</td>
</tr>
<tr>
<td>Surgical Site Infections</td>
<td>X*</td>
<td>Finalized FY 16</td>
<td>Finalized FY 16</td>
</tr>
<tr>
<td>Vascular cath-assoc. infections</td>
<td>X**</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90/ CLABSI</td>
</tr>
<tr>
<td>Foreign object retained after surgery</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air embolism</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Blood incompatibility</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Pressure ulcer stages III or IV</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Falls and trauma</td>
<td>X***</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>DVT/PE after hip/knee replacement</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
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<tr>
<td>Manifestations of poor glycemic control</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Iatrogenic pneumothorax</td>
<td>X</td>
<td>PSI-90 FY 2015</td>
<td>PSI-90 FY 2015</td>
</tr>
<tr>
<td>Ventilator associated events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methicillin resistant Staph. aureus (MRSA)</td>
<td></td>
<td>Finalized FY 17</td>
<td>Finalized FY 17</td>
</tr>
<tr>
<td>Clostridium difficile (CDAD)</td>
<td></td>
<td>Finalized FY 17</td>
<td>Finalized FY 17</td>
</tr>
</tbody>
</table>

* SSI includes different conditions. ** Vascular Catheter is broader than the CLABSI measure. *** Hip Fracture in PSI-90
Hospital-acquired Condition (HAC) Reduction Program

- No changes to the ongoing policy where certain HACs can’t qualify a case for a higher paying DRG tier – but CMS proposes that the ICD-10-CM/ICD-10-PCS Version 33 HAC list replace the ICD-9-CM Version 32 HAC list

- HAC Reduction program reduces total payments by 1% for worst performing quartile of hospitals starting in FY 2015

- Two domains:
  1. Agency for Healthcare Research and Quality measure
  2. Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN) measures

- FY 2016 reports released in late summer via QualityNet, hospitals have 30 days to review
National Performance
Total Penalties by Percentage – FY 2015 Final

- 78% of all facilities receive a readmissions penalty
- 22% get HAC penalty
- 45% get penalties under VBP
- Greatest penalty percentage penalty combined was 4.4%
- More than one in four hospitals experienced zero penalty or a net gain in the quality per-for-performance programs

*Chart includes hospitals that did not meet minimum measure/data requirements*
OTHER PERTINENT PHARMACY RELATED ISSUES

- Escalating Specialty Drug Costs prompting state responses
- FDA requires drug shortage notifications in final rule
- GAO to evaluate 340 B program for any significantly higher Medicare B costs or utilization
What are 4 areas of focus we should all be working on?

- Safety Across the Board
- Patient Family Engagement
- Medicare Spending Per Beneficiary
- Readmission - Specifically Care Coordination
All 26 Hospital Engagement Networks (HENs) contributed to the Knowledge Base for the Guide

Guide provides framework of fundamental concepts and ways every hospital executive can commit to providing safe care and for achieving "Safety Across the Board"

“Safety Across the Board”

Driven by four imperatives:

I. Establish a Culture of Safety
II. Engage the Patient and Their Family
III. Create Safety Across the Board
IV. Count All Harms
Push the Business Case for Safety

Safety should be a strategic initiative in the hospital’s financial plan

Generating Cost Savings

Actions you can start now:

1. Create your Cost Calculating team: The financial expert is the QI champion. Include front line staff and financial and clinical executives.

2. Gain a greater understanding from multiple perspectives for quality improvement and cost reduction initiatives. Understand the financial perspectives from:
   - Patient
   - Payor
   - Hospital
   - Community

   Multiple perspectives provide a greater understanding to cost reduction & savings.

3. Create clear definitions and understand how to identify and measure costs associated with harm:
   - Know how to capture the financial benefits of safety improvement
   - Learn what actions can be taken to lower costs for patient, paye, hospital, and community

4. Follow guiding principles:
   - Use accessible data
   - Minimize resource investment
   - Include post-acute spending to the cost of harm
   - Compare and learn using available datasets for value comparison across institutions

5. Understand the causal relationship between quality of care and its effect on cost.

6. Consider the implication on cost of harm (emotional and financial) to the patient beyond the hospital visit.
Safety Across the Board - SAB

Culture of Safety
- Engagement of leadership at all levels
- Ensuring a Just Culture with all disciplines
- Accountability that is Fair and Expected
- Environment that fosters Speaking Up and Safe Communication

Patient Family Engagement
- Engaging Patients and Families in Care/ DC
- Pre-op huddle
- Informed Consent
- Bedside shift report
- Communication Board
- PFAC

Create SAB
- Building Capacity
- Creating Highly Reliable Organizations
- Continually Striving for Excellence

Count all Harms
- Commit to Transparency
- Put a Face on It
- Scrutinize every failure
- Embrace N=1
- Connect the staff to the work

Safety Across the Board - SAB
- Create SAB
- Count all Harms
- Patient Family Engagement
- Culture of Safety

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IMPACT OF FOCUS ON PATIENTS AND FAMILIES

Insanity- Doing the same thing over and over again and expecting different results

“The voice of 19,550 patients over 3.5 years did nothing to change the way we delivered Care”

- “Too big and complex”
- “Our patients are different”
- “Failure = weakness”
- Shared only the good data
- Spent our energy arguing statistical validity
- Ignored the numerator (n=1)
- Hid behind the denominator when convenient

### Typical HAC Report to the Board

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>PATIENT NAME</th>
<th>LOS</th>
<th>HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Vascular catheter associated infection</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Trauma - fall</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Catheter associated UTI</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Trauma - fall</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>Vascular catheter associated infection</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>Trauma</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>Trauma</td>
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<tr>
<td>8</td>
<td></td>
<td></td>
<td>Vascular catheter associated infection</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td>Pressure Ulcer - Stage III</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>Air Embolism</td>
</tr>
</tbody>
</table>
Failures that Have Faces New Harm Report

March 2012 HACS

TC
49 year old
CVL infection
24 day LOS

RH
66 year old
Femur Fracture
10 day LOS

SS
73 year old
UTI due to Foley
9 day LOS

JJ
54 year old
Finger dislocation
3 day LOS

EC
50 year old
Fracture fingers
24 day LOS

LT
3 month old
Air embolism
19 day LOS

RL
27 year old
CVL Infection
74 day LOS

EC
66 year old
Pressure Ulcer III
64 day LOS

KC
48 year old
Fractured fingers
19 day LOS

Pictures are stock photos – not real patients!
Change in Employee Perspective of Hospital’s Engagement in Quality and Safety

- The organization is committed to quality care
- Patient safety concerns are actively addressed
Hospital ranking in 3 compare groups
Premier Hospital Engagement Network (HEN) – Partnership for Patients

Improvements in Safety Across the Board

CMS Patient and Family Engagement Metrics (P1-P5) Correlation* with Higher Adverse Event Z-scores

<table>
<thead>
<tr>
<th>Metric</th>
<th>Correlation</th>
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<tbody>
<tr>
<td>VTE</td>
<td>0.2</td>
</tr>
<tr>
<td>EED</td>
<td>0.3</td>
</tr>
<tr>
<td>OB</td>
<td>0.4</td>
</tr>
<tr>
<td>CAUTI</td>
<td>0.2</td>
</tr>
<tr>
<td>VAP</td>
<td>0.1</td>
</tr>
<tr>
<td>PU</td>
<td>0.15</td>
</tr>
<tr>
<td>INJ</td>
<td>0.1</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.05</td>
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</table>

*Spearman’s Correlation (p<0.05)

We have identified a direct correlation in reduced harms to consistent focus on Patient and Family Engagement (PFE).

- P3: Prior to scheduled admission, hospital staff provides and discusses a planning checklist and allows time for Q&A.
- P3: Hospitals conduct shift change huddles and bedside reporting with patients and family members in all feasible cases.
- P3: Hospitals have a dedicated person or functional area proactively responsible for PFE and systematically evaluates PFE activities.
- P4: Hospital has an active PFE Committee or at least one former patient that serves on a patient safety or quality improvement committee or team.
- P5: Hospital has at least one or more patient(s) who serve on a governing or leadership board and serves as a patient representative.
FY 2017 Finalized Revision

- Clinical Care
  - Process (5%)
  - Outcomes (25%)
- Patient and Caregiver Experience
- Efficiency and Cost Reduction
  - Safety (20%)

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>NQS-Based Domain</th>
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<tbody>
<tr>
<td>AMI-7a</td>
<td>Clinical Care – Process</td>
</tr>
<tr>
<td>IMM-2</td>
<td>Clinical Care – Outcomes</td>
</tr>
<tr>
<td>PC-01 <em>NEW</em></td>
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<tr>
<td>MORT-30-AMI</td>
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<tr>
<td>MORT-30-HF</td>
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<tr>
<td>MORT-30-PN</td>
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<tr>
<td>HCAHPS</td>
<td>Patient and Caregiver Centered</td>
</tr>
<tr>
<td></td>
<td>Experience of Care / Care Coordination</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Safety</td>
</tr>
<tr>
<td>CLABSI</td>
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</tr>
<tr>
<td>MRSA <em>NEW</em></td>
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<tr>
<td>C. Diff <em>NEW</em></td>
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<tr>
<td>PSI-90</td>
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<tr>
<td>SSI</td>
<td></td>
</tr>
<tr>
<td>MSPB-1</td>
<td>Efficiency and Cost Reduction</td>
</tr>
</tbody>
</table>
Medicare Spending per Beneficiary
“The why behind the what”

In 2013, spending on Medicare accounted for 14% of the federal budget
• 27% of national spending on acute care
• 23% of spending on physician services

Net Medicare outlays projected to increase from $512B in 2014 to $858B in 2024
• Key factors: Growth in Medicare population & health care costs

MSPB is designed to:

- Reward efficiency
- Recognize performance
- Reinforce integration
- Reduce variation

1The Kaiser Family Foundation, 2014
2Centers for Medicare & Medicaid Services, 2014
MSPB 2015 in summary
What it is… and what it is not

What it is…

• A combination of Medicare Parts A and B spending between 3 days prior to inpatient admission and 30 days post discharge
• Adjusted using age and severity of illness
• A calculation expressed as an observed to expected ratio… if > 1, care is more expensive than the national median

… and what it is not

• A measure of hospital costs to deliver care
• A proxy for inpatient resource utilization
• A static measure… weighting increases with the potential to diversify in future fiscal years
Medicare Spending per Beneficiary
Episode spending across the continuum

1 to 3 days prior to index hospital admission

During index hospital admission

1 through 30 days after discharge from index hospital admission

Cross-continuum claim settings

Home health agency
Hospice

Inpatient
Outpatient
Skilled nursing facility

Durable medical equipment
Carrier
MSPB: Which measures will be next?

Efficiency Domain- considering six new episode of care measures (not in IQR yet)

- Three medical episodes: kidney/urinary tract infection; cellulitis; and gastrointestinal hemorrhage

- Three surgical episodes: hip replacement/ revision; knee replacement/ revision; and lumbar spine fusion/ refusion
### MPSB Data Sources and Potential Uses

#### National MSPB Data (Hospital Compare)
- Comparison to state and national providers
- Comparison of price standardized spend per claim
- Intra-system comparisons

#### Hospital Specific MSPB Data (Quality Net)
- Post acute care patterns and variation in care
- All Cause readmission
- Variations in spending in condition
- Variations in spending by provider and setting of care
Medicare Spending per Beneficiary

Breakdown of hospital-specific data

**MSPB data includes:**

- Hospital-specific MSPB measure ratio
- MSPB amount during the performance period
- National distribution of MSPB ratios
- Categorical breakdowns by claim type
- Spending breakdown by Disease Category
- Patient-level admission and episode files

**Publicly-available (HospitalCompare)**

**Hospital-specific (QualityNet)**

**Hospital-specific (QualityNet)**

**Patient-level files**
Understand the measure and educate key stakeholders

Analyze your performance data – both via QualityNet and your hospital claims data

Develop an improvement strategy and engage acute and non-acute stakeholders

Implement improvement plans for identified gaps… clinically integrated care and harm reduction will be key

Monitor impact of interventions implemented

Medicare Spending per Beneficiary
Strategies for improving performance
Managing care across the continuum most effective when:

- Care management functions are coordinated across all points of care and among providers
- Processes and tools are consistent and hard-wired

Consider:

- Assessment of system-wide care management capabilities/functions
- Development of prioritized recommendations to implement system-wide populations management care coordination and care management strategies
- Design and implementation of the system-wide care management model and framework
- Implementation of population-specific and level of care specific care management capabilities synchronized with the system
- Care Management staff training including competencies required to manage populations
- Tools and processes for optimal transition planning and consistent handoffs
- Monitoring/reporting of data, including impact of changes from implemented improvement efforts
25% nation’s hospitals in 75 selected areas will be required to participate

Episodes of hip and knee replacement

All services from hospital admission thru 90 days post discharge

Billing reconciliation of actual to target

Also rated on 3 quality measures:
  • Complication rates
  • Readmission rates
  • Consumer experience under HCAHPS
Summary

- We are on a rapid course with HCR to move all providers from fee for service to alternative payment models.
- All provider payment programs have aligned focus on quality measures to create opportunities for conversations and work across the continuum.
- Pharmacy is in a pivotal position to support the success of these changes through their expertise, skill sets, and position in the health care system. Areas to consider for support include:
  - Harm reduction - Ex. Antibiotic Stewardship
  - Patient Family Engagement
  - Cost reduction and Coordination of care across the continuum
THANK YOU

Monica_Barrington@premierinc.com
www.premierinc.com
THANKS FOR ATTENDING!

JOIN US TUESDAY, SEPTEMBER 8:
340B COMPLIANCE: I SURE WISH I WOULD HAVE KNOWN THAT!

Questions? Contact Laura Miller at lmiller@iarx.org or 515-270-0713