2014 Quality Reporting: Affecting Your Bottom Line

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Quality Drives the System

"Quality metrics are only as good as the data collected; hence, the reliability and validity of the quality data collected is critical."

--Deloitte Center for Health Solutions

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Intersection of the Value Based Incentive Programs

- **2003:** Beginning of hospital quality pilots for CMS with Inpatient Quality Reporting Program (IQR)
- **2006:** Physician quality program (PQRI) begun
- **2009:** Meaningful Use introduced in HITECH Act
- **2010:** Affordable Care Act passed with emphasis on value based payments
- **2011:** Stage 1 Meaningful Use begins with required clinical quality measures
- **2012:** Beginning of value based purchasing program
- **2013:** Introduction of readmission metrics
- **2014:** Stage 2 Meaningful Use with increased quality reporting; introduction of mortality measures into VBP
- **2015:** Addition of "Medicare spending per beneficiary" efficiency metrics
- **2017:** Stage 3 Meaningful Use???????

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Quality Bonuses and Penalties in 2014

- Two incentive programs to affect hospital reimbursements based on 2014 measures:
    1) Value Based Purchasing: 24 quality measures from 3 areas
    2) Readmissions within 30 Days

- Three incentive programs to affect physician/provider future reimbursements:
    1) PQRS
    2) E-Prescribing
    3) Value-Based Payment Modifier

- These quality programs are overlaid on the Meaningful Use incentive programs
    1) 16 quality measures for hospitals
    2) 9 quality measures for physicians

Hospital Quality Incentives/Adjustments

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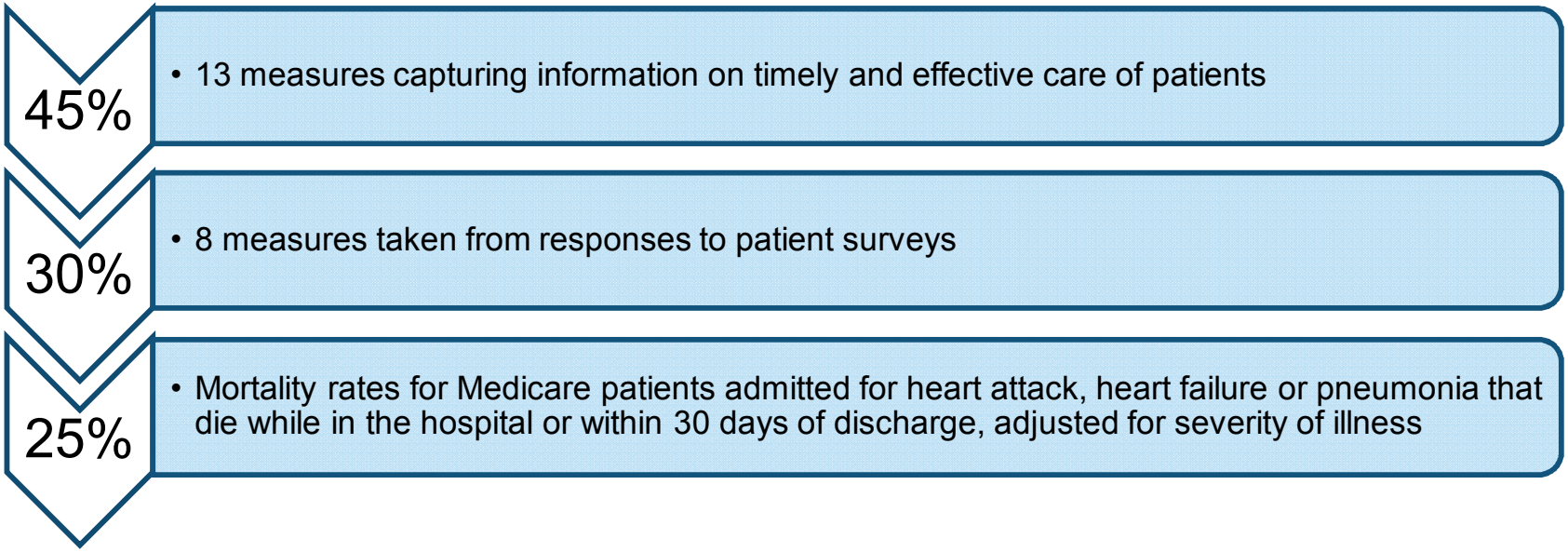
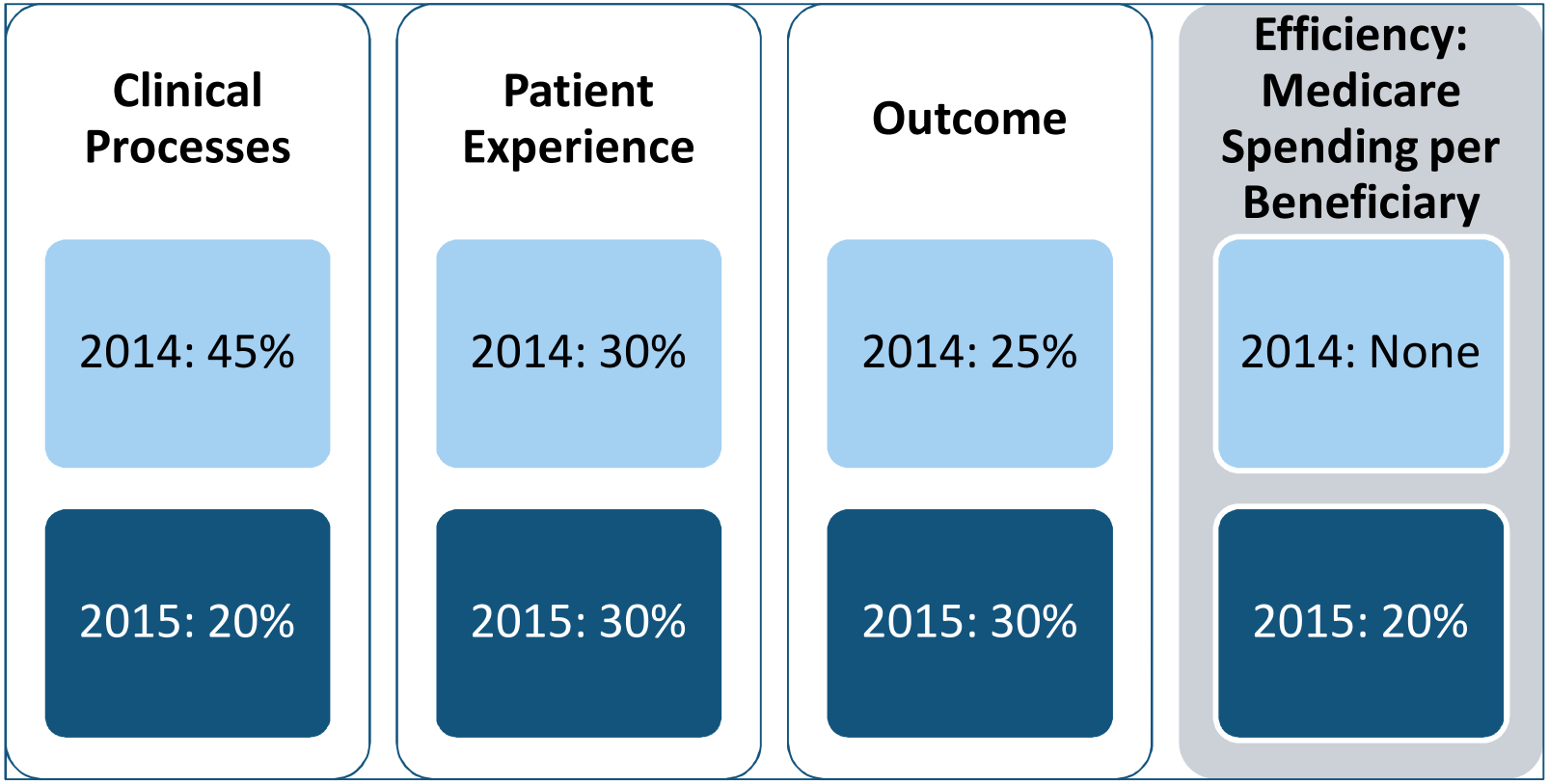
2014 Medicare Hospital Value-Based Purchasing



2015 Medicare Hospital Value-Based Purchasing



How This Affects Your Reimbursement

- CMS removed $1.1 Billion from hospital reimbursements to fund the Value Based Purchasing program.
- Each hospital's reimbursement was cut from the DRG reimbursement rate:

Fiscal Year	% Reduction
2013	1.0
2014	1.25
2015	1.5
2016	1.75
2017	2.0

- Hospitals can earn back an incentive payment that is less than, equal to, or more than the amount decreased.
- Each hospital's incentive is calculated by comparing current metrics to other hospitals ("Achievement") and on the hospital's own past performance ("Improvement")

45%: Quality Measures for Processes; Relation to Meaningful Use

- **Averting Blood Clots in Heart Attack Patients.** Percent of heart attack patients given medication to avert blood clots within 30 minutes
- **Quick Response to Heart Attacks.** Percent of heart attack patients given percutaneous coronary interventions within 90 minutes
- **Discharge Instructions.** Percent of heart failure patients given instructions upon discharge about how to take care of themselves.
- **Taking Blood Cultures.** Percent of pneumonia patients who had a blood culture taken before they were given antibiotics.
- **Correct Antibiotic Selection for Pneumonia Patients**. Percent of pneumonia patients that received the correct antibiotics.
- **Prompt Antibiotic Treatment.** Percent of patients that received an antibiotic within an hour of surgery.
- **Correct Antibiotic Selection for Surgical Patients**
- **Prompt Cessation of Antibiotics.** Percent of patients who had their antibiotics stopped within 24 hours of surgery.
- **Controlling Blood Sugar.** Percent of heart surgery patients who had their blood sugar kept under control after an operation.
- **Beta Blockers for Surgery Patients**. Percent of heart surgery patients already taking beta blockers who were given a beta blocker just before and after surgery.
- **Averting Blood Clots in Surgery Patients.** Percent of surgery patients who received an appropriate treatment to prevent blood clots.
- **Prompt Cessation of Blood Clot Treatment.** Percent of surgery patients who received anti-blood clot treatment within 24 hours before to 24 hours after the operation.
- **Averting Catheter Infections.** Percent of patients with a urinary catheter where it was removed within 48 hours after surgery.

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30%: Patient Satisfaction

- How well nurses communicated with patients.
- How well doctors communicated with patients.
- How responsive hospital staff were to patients' needs.
- How well caregivers managed patients' pain.
- How well caregivers explained medication to patients before giving it to them.
- How clean and quiet the hospital room and hall were.
- How often caregivers explained to patients how to take care of themselves after discharge.
- How the hospital stay rated overall.

Value Based Purchasing: Where We Are

	Pct. Of Hospitals Receiving Bonus	Pct. Of Hospitals Receiving Penalty	Total No. of Hospitals	No. of Hospitals Receiving Bonus	No. of Hospitals Neither Bonus Nor Penalty	No. of Hospitals Receiving Penalty	Average Bonus	Average Penalty	Average of Net Bonuses and Penalties
Ohio	51%	47%	116	59	3	54	**0.25%**	**-0.21%**	**0.03%**
U.S. Average	45%	53%	2728	1231	46	1451	**0.24%**	**-0.26%**	**-0.03%**

- Hospitals exempted from Value Based Purchasing Penalties: Critical Access Hospitals, certain cancer centers, rehab facilities, psychiatric facilities, LTC, Children's Hospitals and those with too small a patient population
- Ohio is higher in bonuses than any of the surrounding states except Indiana which has 57% of its hospitals receiving bonuses

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Physician/Provider Quality Incentives

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PQRS and Reimbursement

- **Groups of 100 or more providers reporting under a single tax ID**: Starting with 2013 PQRS data, physicians fee schedule reimbursement for 2015 is determined by PQRS data by applying a value-based modifier.
- **Groups of less than 100 providers:** PQRS data expected to be used to determine reimbursement in 2017, but details not developed yet.
- **Groups exempt:**

  1) Groups participating in ACOs
  2) Physicians billing under CAH or Method II billing
  3) FQHCs or rural health clinics

Quality Reimbursement for Groups of 100+ Providers

- **Definition of Group:** All providers under a common tax ID including physicians, dentists, chiropractors, nurse practitioners, PAs, CRNAs, CNS, CNM, social workers, psychologists, dieticians, audiologists, physical therapists, occupational therapists and speech language therapists.
- **Value based modifier:** Applied using the statistics from PQRS reporting as well as cost figures for treatment of heart failure, diabetes, chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD).
- **Option for Quality-Tiering Election for Value-Based Modifier:** If group opts to participate in quality tiering, then can see reimbursement either increase, decrease or remain the same depending on comparison to national averages.
- **Potential Bonus for Quality-Tiering Election:** +2.0%

How Meaningful Use and IT Can Support the Quality Initiatives

- Review **clinical decision support rules** to make sure they are capturing clinical quality measures
- Appoint a **quality coordinator** as well as an **IT report specialist devoted to quality reporting**
- Have clinical staff review **protocols for patient care**
- Establish a team to review **patient stay from the patient perspective**
- Do a retrospective review of measures **from 2 -3 years ago to establish a baseline**
- Have **Meaningful Use team meet regularly with quality incentives team**

Questions?

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