


From RHQDAPU to HVBP:
Deciphering the Alphabet Soup of Health Care Reform

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Free Beer!



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Overview

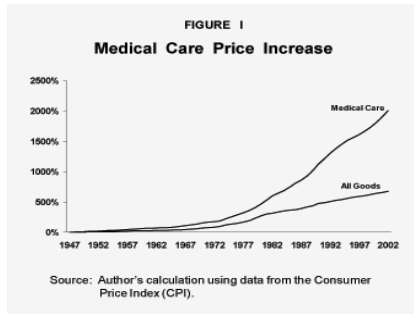
- Review the imperative for healthcare delivery reform
- Discuss the components of value driven healthcare
- Discuss delivery reforms that will likely change the way in which we practice medicine

- Healthcare spending is projected to grow 6.7% annually from 2007 - 2017.
- The Medicare Hospital Insurance Trust Fund will be exhausted in 2024.
- > 50% of all personal bankruptcies are attributed to inability to pay healthcare costs.

Himmelstein, DU et al. Health Affairs Marketwatch 2/2/05
<http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>
<https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf>

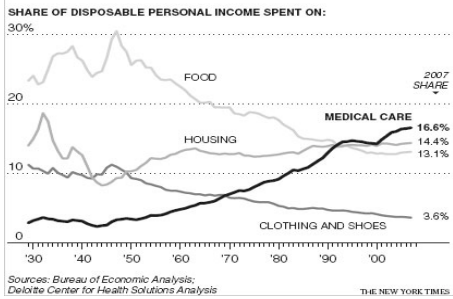
Skyrocketing Healthcare Costs

www.ncpa.org/pub/ba/ba437/ba437fig1.gif



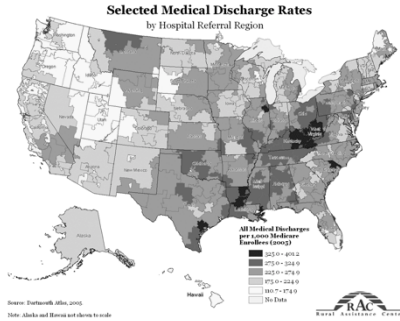
The Mounting Burden for Health Care

Spending on health care, which takes up more of consumers' income than housing, food or clothing, has risen significantly since 2000. As the economy slows and medical costs continue to rise, millions of people may be unable to afford care.

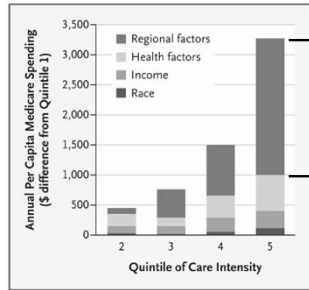


Inexplicably Variable Resource Utilization

http://www.raconline.org/maps/mapfiles/hrr_discharge_rates.png



Stop Blaming It On The Patients

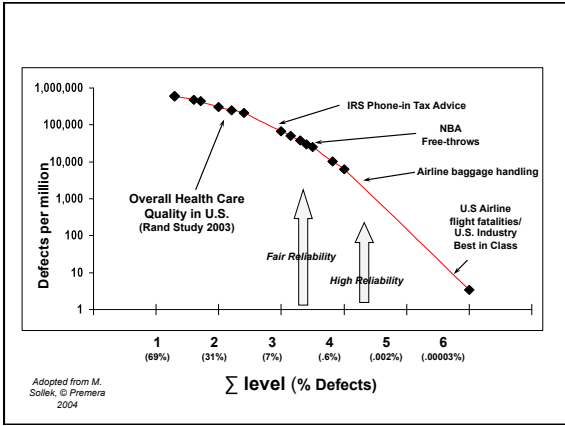


Sutherland et al. NEJM 361:13

The Quality Chasm

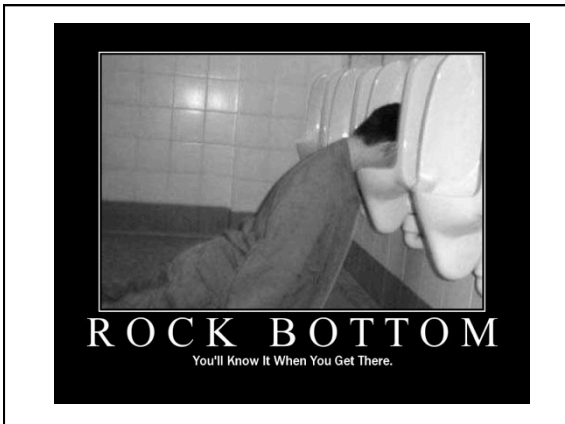
- 44,000-98,000 inpatient deaths per year attributed to medical errors
 - 8th leading cause of death, exceeding MVA, breast cancer and AIDS
 - Equivalent to one jet airliner crashing every day.
 - Cost: \$17-29 billion per year
- 17 year lag between best practice publication and widespread incorporation into practice
- 54.9% of patients with chronic conditions receive recommended care

"To Err is Human: Building a Safer Health System"; Institute of Medicine, 1999
McGlynn et al, N Engl J Med. 2003;348:2635-2645



Healthcare Delivery in the USA

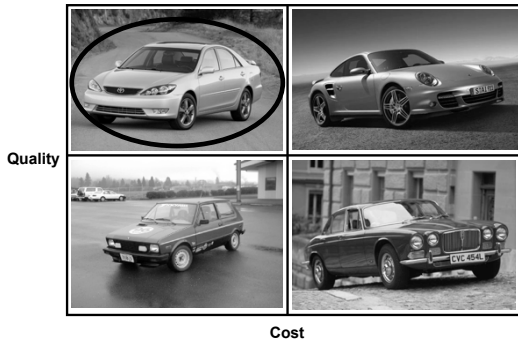
- Skyrocketing costs and unsustainable inflation
- Inexplicable variability in cost and outcomes
- Huge quality lapses



Achieving High Value Healthcare

$$\text{Value} = \text{quality} / \text{cost}$$

We Think In Terms of Value



...But It Doesn't Apply to Healthcare

Dysfunctional incentives drive dysfunctional performance

- Consumers have limited tools for measuring value
- Compensation is unrelated to performance
- Perverse incentives
 - The worse we do, the more we make
 - Disincentives for prevention or population management
- Innovation is hamstrung by archaic statutes

Achieving High-Value Healthcare

Change the incentives

- Make value transparent to consumers
- Reward high value rather than high volume
- Remove perverse incentives
- Align incentives through global accountability
- Get rid of statutes that get in the way of meaningful reform

Step One: Transparency

Give payers and consumers access to provider performance and cost data to allow them to determine where the best healthcare values are.

RHQDAPU “Rack-da-poo”

Reporting Hospital Quality Data for Annual Payment Update
http://www.cms.hhs.gov/HospitalQuality/Inits/08_HospitalRHQDAPU.asp

- CMS hospital pay for reporting program mandated by Congress in 2003
- Hospitals report adherence to > 50 process quality measures, mortality rates, billed cost per DRG and patient satisfaction surveys (HCAHPS)
- Hospitals that do not participate have 2% of their annual Medicare Payment Update withheld
- In 2007, 95% of eligible hospitals participated

2012- 2014 RHQDAPU Measures

http://www.cms.hhs.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp

AMI

- ASA at arrival and discharge
- ACE / ARB for LVSD
- Beta blocker and statin at discharge
- Thrombolysis within 30 minutes
- Timing of receipt of PCI
- Smoking cessation counseling

Heart Failure

- Left ventricular function assessment
- ACE / ARB for LVSD
- Discharge instructions
- Smoking cessation advice/counseling

Pneumonia

- Timing of initial antibiotic upon arrival
- BCx performed before first antibiotic
- Appropriate initial antibiotic selection
- Smoking cessation counseling

SCIP

- Appropriate prophylactic antibiotic within 1 hour of incision, and DC' ed within 24 hours
- VTE prophylaxis within 24 hours of surgery
- Continuation of pre-op beta blockers
- Appropriate hair removal
- Urinary catheter removal at 1-2 days

30 Day Readmission and Mortality

- AMI
- Heart failure
- Pneumonia

Other stuff

- Iatrogenic pneumothorax
- Post-op respiratory failure, VTE, wound dehiscence
- CLABSI, CAUTIs, surgical site infections
- Failure to rescue

HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems

- Subset of RHQDAPU
- Standardized survey methodology for measuring and publicly reporting patients' perspectives of hospital care
- Publicly reported quarterly since March, 2008
- 27 questions:
 - Communication with doctors and nurses
 - Responsiveness of hospital staff
 - Cleanliness and quietness of hospital
 - Pain management
 - Communication about medicines
 - Discharge information
 - Overall rating and recommendation of hospital

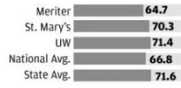
Hospital Compare

www.hospitalcompare.hhs.gov

- CMS website that displays RHQDAPU hospital data to the public
- Data reported and updated quarterly
- Can compare hospitals head to head, and to state and national averages

Patient satisfaction

Meriter Hospital scored worse than the national average in seven of 10 categories in the first patient satisfaction survey to be released on a federal Web site. St. Mary's fared worse than the national average in three categories and UW Hospital was worse in one. The average percentage of patients who said hospitals did well in each of the categories:



NOTE: The categories range from how well doctors and nurses communicate to how clean and quiet patient rooms are.

For more information, go to: www.hospitalcompare.hhs.gov

SOURCE: U.S. Department of Health and Human Services State Journal

Wisconsin State Journal, April 8, 2008

Madison HCAHPS Data, August 2009

	UNITED STATES	WI	UWHC	Meriter	St Mary's
YES Patients would definitely recommend	68%	71%	81%	77%	79%
YES Patients would probably recommend	27%	25%	17%	21%	18%
NO Patients would not recommend	6%	4%	3%	4%	3%

Public Humiliation: Hey, It's A Start



"Sorry about the misunderstanding. Sometimes my G's look like S's."

P4P / VBP

Pay people and systems based on the quality of their services, rather than just the volume.

Does P4P Drive Higher Value?

<http://www.premierinc.com/quality-safety/tools-services/p4p/qi/index.jsp>

CMS / Premiere Hospital Quality Initiative Demo

- CMS demonstration project beginning in 2006
- Measured adherence to best practices and patient outcomes: AMI, CABG, pneumonia, CHF, knee / hip replacement
- “Carrot and stick” approach:
 - \$17.5 million incentive allocated to top performers
 - Top 10% received 2% bonus
 - Bottom 20% returned 1-2% of their DRG payments

CMS/Premiere Outcomes

<http://www.premierinc.com/about/events-education/newsletters/nexus/08-updates/P4P-II-Nexus020608.jsp>

- Average improvement of 17.2% in 30 care measures
- 1.87% mortality reduction in the 5 diagnosis groups
- If performance improvements in these 5 domains were generalized to all US hospitals:
 - 70,000 fewer in-hospital deaths per year
 - \$4.5 billion in annual savings

Incentives and Transparency Appear To Be Synergistic

- Measured hospital adherence to 10 quality measures over two years
- 406 facilities that only reported: 5.2% improvement
- 207 facilities that reported and participated in HQID program: 9.5% improvement

- Recent data from Premier:
Participants were 6.8% better (94.6% vs 87.4%) than non-participants in 19 performance measures

Lindenauer et al. NEJM. 2007; 356: 496-496.
http://www.premierinc.com/about/events-education/newsletters/nexus/08-updates/P4P-II_Nexus020608.jsp

Pay For Performance Is Coming Soon

www.hhs.gov/news/press/2011pres/04/20110429a.html

- In 2013 RHQDAPU morphs into HVBP
- 1% of hospital reimbursement withheld to fund program; gradual increase to 2%
- \$850 million of incentive available to hospitals based on performance

- Key points:
 - There will be winners and losers
 - Your hospital cares deeply about this

Implications of Existing Reforms

- First salvo of accountability aimed at hospitals

- Hospital margins are increasingly dependent upon performance... much of which is controlled by physicians... who don't necessarily share the same incentives

- Hospitals see survival contingent upon "aligning" their medical staffs

Rearranging the Deck Chairs on the Titanic?

- We're still paying for the wrong things
- Not enough money at risk to change behavior
- Health care still broken into competitive silos, with no incentives to collaborate
- No impact on inflationary pressure
 - Treatment remains far more lucrative than prevention
 - Margins still hinge upon a few very expensive procedures
 - Incentives (financial and legal) still reward resource overuse

Incentives Really Matter

Ann Int Med, 2011. 155 (3) 152-159

- The Good:
 - Hospitalist inpatient LOS 0.64 days lower
 - Hospital charges \$282 lower
- The Bad:
 - Medicare costs 30 days post-discharge \$332 higher
 - Less likely to be discharged home (OR: 0.82)
 - More likely to have ED visits (OR:1.18)
 - More likely to be readmitted (OR:1.08)

Decreased length of stay and hospital costs associated with hospitalist care are offset by higher medical utilization and costs after discharge.



The “Game Changers”

- Center for Medicare and Medicaid Innovation (CMMI)
- Independent Payment Advisory Board (IPAB)

CMMI

- Mandated to test innovative payment and delivery models to reduce expenditures while preserving or enhancing quality
- \$10 billion in direct funding for new projects from 2011 – 2019
- Unprecedented latitude to test and implement innovations
- If a demonstration project proves effective, Secretary of HHS has authority to broaden scope, up to and including applying to the *entire Medicare and Medicaid population*

CMMI Projects

Community Based Care Transitions Program

- Reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program.

Partnership for Patients

- \$500 million allocated to test programs to:
 - Reduce preventable hospital-acquired conditions by 40%
 - Reduce preventable complications during care transitions to reduce hospital readmissions by 20%
- 4,500 organizations (2,000 hospitals) already signed on

Bundled Payments Demonstration Project

Bundled Payments

Hackbarth, et al. NEJM, 2008. 359;1

The Concept

- Offer a single global payment (bundle) to providers and facility for an "episode of care"
- Examples of an "episode":
 - Elective THA with post-op rehab and follow up
 - Admission for ADHF and 30 day follow up
- All care events that occur during the episode are paid under the bundle
 - Cost of care < bundle = profit
 - Cost of care > bundle = loss

CMS ACE Bundling Demo

- Acute Care Episode (ACE) demonstration: Texas, Oklahoma, New Mexico, and Colorado 01/09- 12/11
- Global payment for 28 cardiac and 9 orthopedic surgeries.
- Incentives for doctors and hospitals to work together efficiently
- Leftover funds to be shared by hospital and surgeons
- Price and quality data to be posted publicly

- Similar program 1991 through 1996 tested bundled payment for CABG at 7 hospitals.
 - Estimated 10% savings (approx \$51 million)
 - Nurses and QA staff in most hospitals believed quality improved during the test

CMMI Bundled Payment Demo

4 Demonstration Projects

- Episode = acute hospital stay. Hospitals and physicians paid discounted DRG and FFS, but they get to gainshare in savings accrued from better care.

- Episode = inpatient stay + post-acute care. Physician fees, post-acute care, related readmissions and other services (lab, DME, Part B drugs) included in bundle. Any cost savings compared to baseline are shared among providers.

- Episode = acute hospital stay... but CMS pays a single, prospective bundled payment to the hospital for all services including physician compensation. Hospital divides up the bundle.

Bundling... Disruptive Technology?

Upsides

- Would mandate service integration and coordination
- Create global accountability and decrease cost shifting
- Force systems to decide what really generates value rather than what generates the most RVUs
- Nothing changes behavior or drives change faster than holding risk

Downsides

- Loss of autonomy
- Incentives to exclude high risk patient populations and restrict care
- Sluggish over distribution of the bundle
- Unintended consequences are almost a given

Wait a Minute... Haven't We Seen This Before?



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IPAB... The Nuclear Option

- Medicare reimbursement reforms recommended by MedPAC, but consistently ignored by Congress due to political pressure.
- Starting in 2015, IPAB must restrain net growth in Medicare spending if it exceeds target level.
- IPAB strips Congress of primary authority over Medicare reimbursement policy. HHS required to implement IPAB proposals unless Congress adopts equally effective alternatives.
- Congress cannot override IPAB without 3/5 majority.

Yeah, But...

- IPAB may not be Constitutional: Congress has ceded budgetary authority to unelected, unaccountable (?) entity.
- Significant limits on scope:
 - Can't ration health care, raise revenues, increase premiums or cost-sharing, restrict benefits or modify eligibility criteria.
 - Hospital, inpatient rehab and psych, LTAC, hospice are exempt until 2020.
- Left on the chopping block: Medicare Advantage, Part D drug reimbursement, SNF, home health, dialysis, ambulance and ambulatory surgical center services, DME and *provider reimbursement*



Summary

- We need to fundamentally change the incentives that drive dysfunctional health care reimbursement
- We will increasingly be held financially accountable for quality and adherence to best practices
- Hospitals, providers and payers must have same incentives for any of this to work
- If you remember only two words today:
 - Value
 - Alignment
- If reform initiatives don't make us uncomfortable, they're probably insufficient
