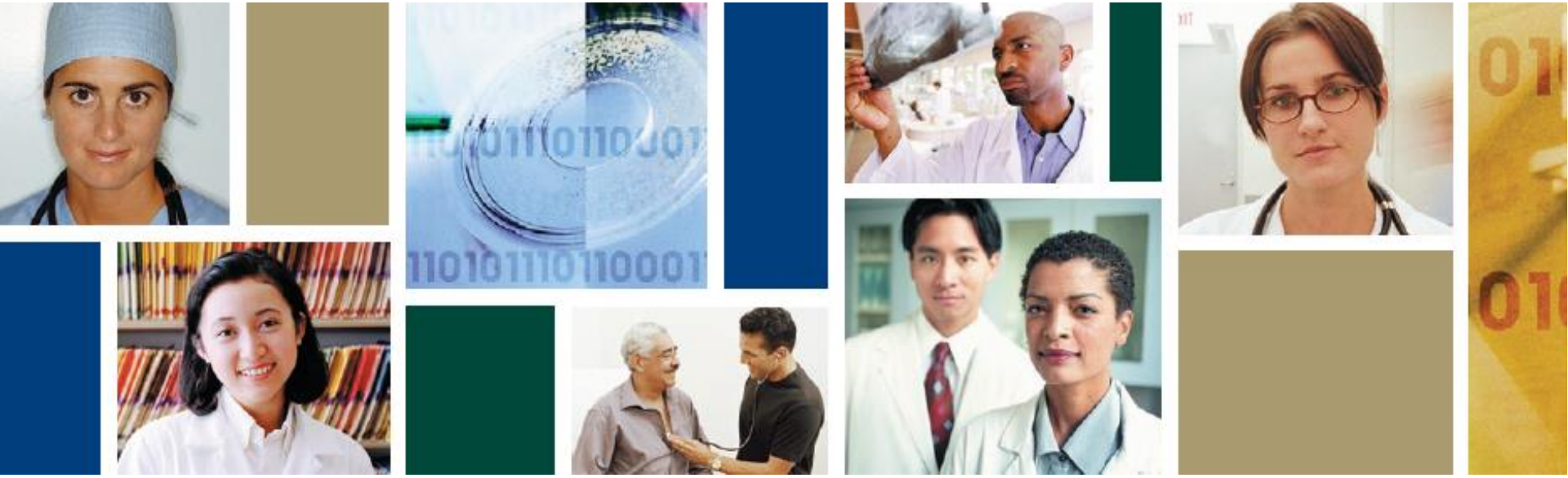


A Systematic Way to Improve Your Medicare Quality Measures with Data Analytics

Presented by: CBIZ KA Consulting Services, LLC

August 3, 2018

Overview

- Medicare quality initiatives
- What role can (does) finance play
- How can we get a handle on the impact – now and where it is headed
- What strategies can we employ to be involved in a meaningful way
- How can clinical and financial work together
- How data analysis can be our friend

Overview – Programs “In Play”

- Hospital quality programs
  - Readmission Reduction Program
  - Value-Based Purchasing
  - Hospital Acquired Conditions

January 2015 Comments on Paying for Quality

- HHS Secretary Sylvia Mathews Burwell
- Goals for CMS
  - Payments fee-for-service Medicare via alternative payment models
    - As of end of 2014: 20%
    - Target 30% by end of 2016 – Goal Met!
    - Target 50% by end of 2018
  - Payments tied to quality or value measures
    - As of end of 2014: 80%
    - Target 85% by end of 2016 – Goal Met!
    - Target 90% by end of 2018

Results of Policy Actions

- Readmission Rates Are Down

Measure	2010	2015	Change
All Conditions	12.9%	10.5%	-2.4
AMI	17.3%	13.7%	-3.6
Heart Failure	19.5%	16.4%	-3.1
Pneumonia	13.1%	10.6%	-2.5
COPD	16.8%	14.2%	-2.6

- Source: MedPAC March 2017 report

Results of Policy Actions

- Risk-Adjusted 30-day post discharge mortality rates have declined

	2010	2016
Unadjusted Mortality	7.2%	8.4%
Expected Mortality	7.5%	10.2%
Risk-adjusted mortality	8.4%	6.7%

- Source: MedPAC March 2018 report

Potential Reimbursement Impact

Hospital Quality Program	Impact
Readmission Reduction Program	-3% to 0%
Value Based Purchasing Program	-2% to 2%
Hospital Acquired Conditions	-1% to 0%
All Quality Programs (theoretical)	-6% to 2%
All Quality Programs (actual)	-3.82 to 1.71%

Overview – Programs “In Play”

- Medicare Quality Measures are Here to Stay
  - The programs are evolving – more detailed
  - Greater financial implications
  - The Medicare program is saving money

Understanding the Opportunity for Change

Hospital Readmission Reduction Program

- Key Reminders:
  - Max of 3% Penalty
  - “All Cause”, though risk-adjusted
  - Based on three-year rolling averages
  - Over $500 million in direct Medicare savings
  - Readmission categories unchanged
    - AMI, Heart Failure, Pneumonia, COPD, Hip / Knee Replacement, CABG

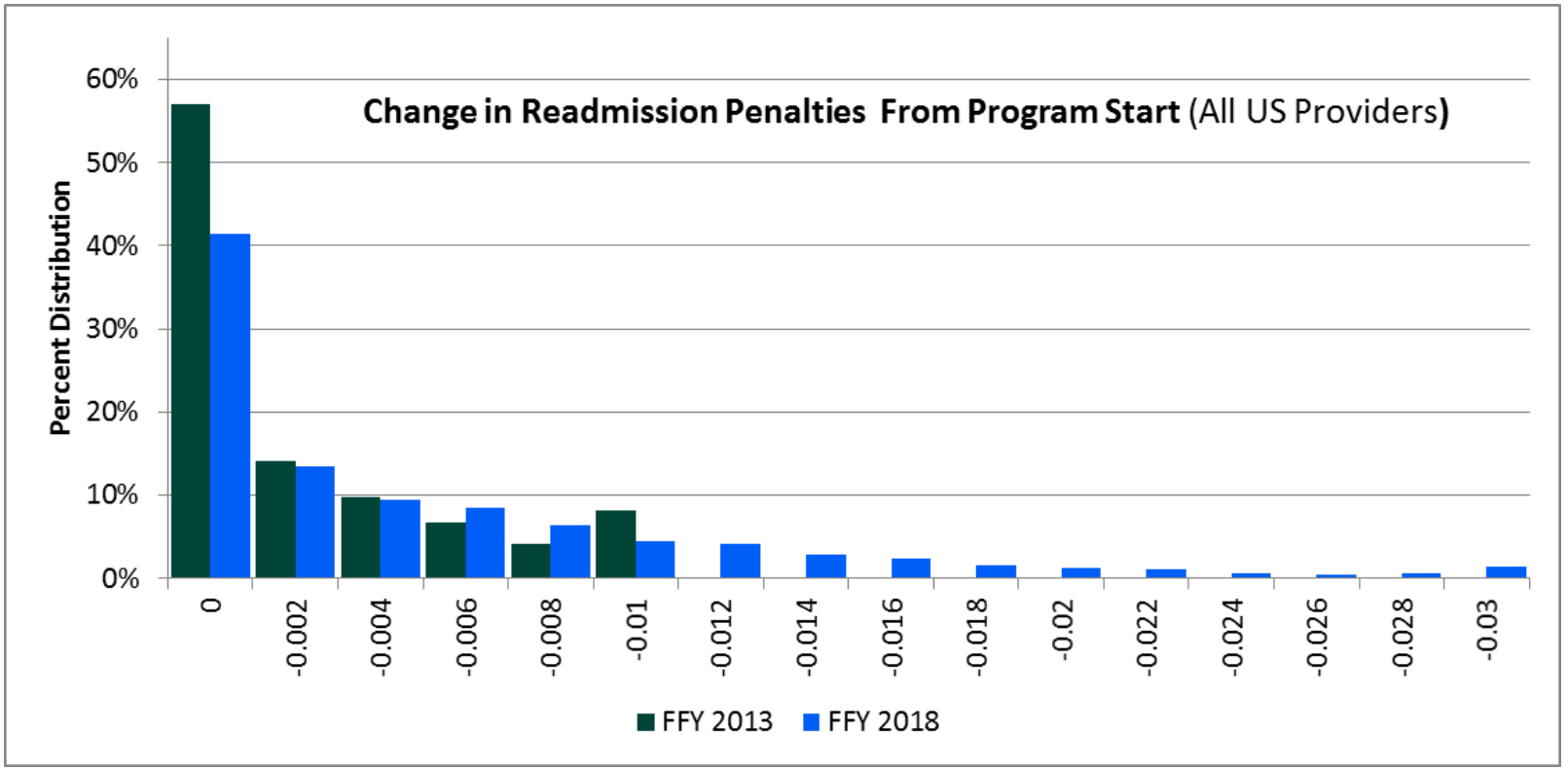
Hospital Readmission Reduction Program

- Excess Readmission Ratio
  - Ratio of Predicted Readmission Rate to Expected Readmission Rate
    - $$\frac{Hospital\ readmisson\ rate\ adjusted\ for\ hospital's\ patient\ mix}{Average\ hospital\ readmission\ rate\ with\ hospital's\ patient\ mix}$$
  - Methodology has been to penalize providers having excess readmission ratios greater than one. This changes in 2019.

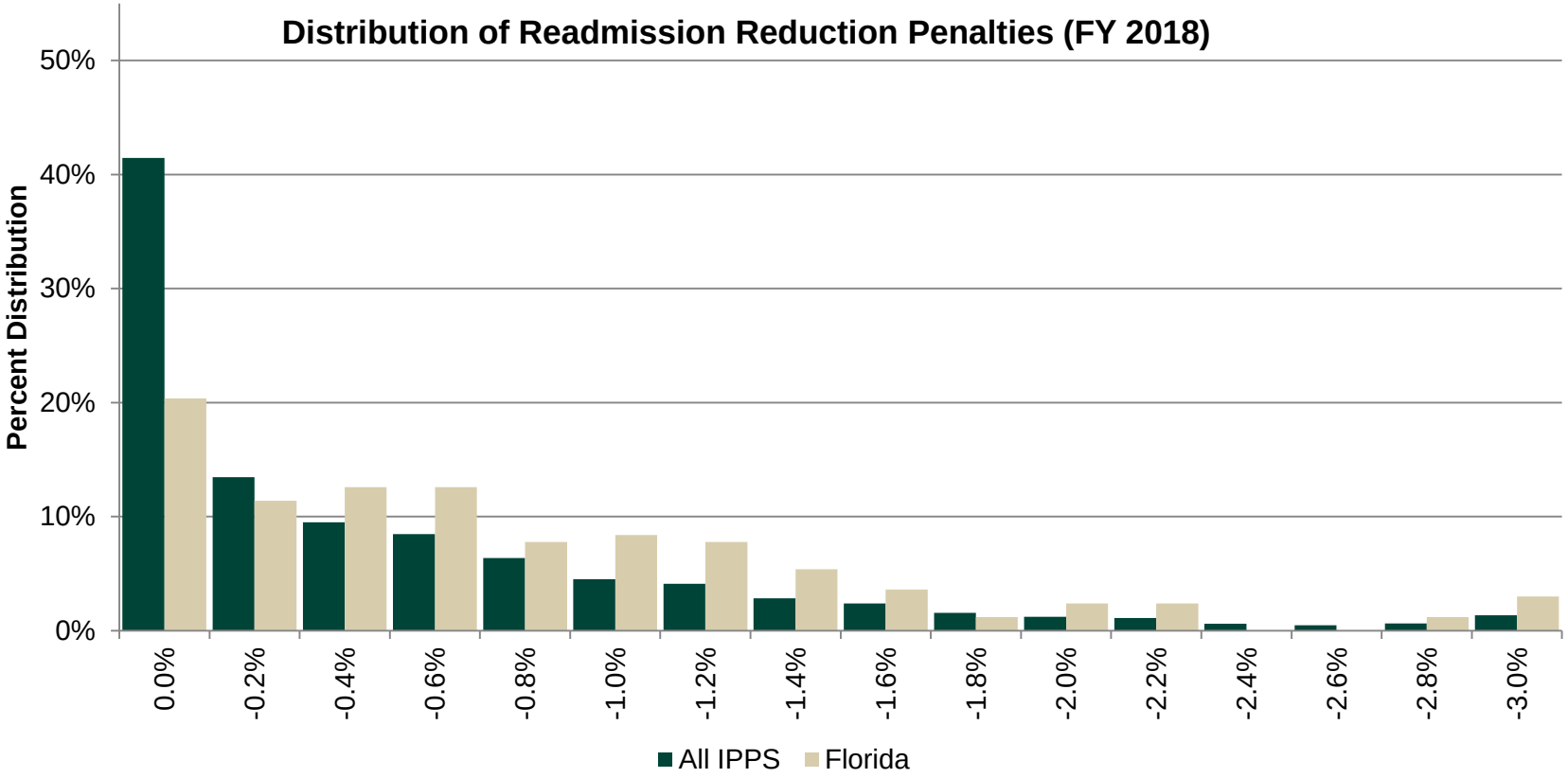
Hospital Readmission Reduction Program

- Excess Readmission Ratio (ERR) **NEW FOR 2019!**
  - 21st Century Cures Act requires CMS to account for socioeconomic factors in HRRP, and directed CMS to use Medicare-Medicaid dual-eligible beneficiaries as the factor
  - CMS implemented the law by stratifying providers into 5 quintiles
  - To escape a penalty, a provider's ERR must now be less than the median in the quintile. Prior methodology required value to be less than 1.

Impact of Expanded Readmission Criteria



Impact of Expanded Readmission Criteria



Wonderful Hospital Center
Review of CMS Readmisson Data
Verification of Excess Readmission Ratios

Predicted Readmission Rate: Hospital readmission rate adjusted for hospital's patient mix
Expected Readmission Rate: Average hospital readmission rate with hospital's patient mix
Nominal Readmission Rate: Hospital readmission rate without adjustment for patient mix

From Table 1 on Hospital Specific Report

Measure	Number of Eligible Discharges at Your Hospital	Number of Readmissions at Your Hospital	Predicted Readmission Rate	Expected Readmission Rate	Excess Readmission Ratio	National Crude Readmission Rate	Monthly Number of Discharges to Monitor	Monthly Number of Readmissions to Affect Change
AMI	633	98	15.6%	15.7%	0.9932	16.0%	18	0.0
COPD	826	174	21.0%	20.8%	1.0074	19.8%	23	0.1
HF	1,771	405	22.6%	21.2%	1.0681	21.6%	50	0.8
PN	1,476	217	15.0%	16.1%	0.9304	17.0%	41	0.0
CABG	212	31	14.2%	13.8%	1.0303	13.6%	6	0.1
THA/TKA	992	46	4.6%	4.6%	1.0115	4.3%	28	0.1
	A	B	C	D	E	F	G = A / 36	H = (1-E)*B/36

From Supplied Data

Measure	Number of Eligible Discharges at Your Hospital	Number of Readmissions at Your Hospital	Predicted Readmission Rate	Expected Readmission Rate	Excess Readmission Ratio
AMI	633	98	15.6%	15.7%	0.9932
COPD	826	174	21.0%	20.8%	1.0074
HF	1,771	405	22.6%	21.2%	1.0681
PN	1,476	217	15.0%	16.1%	0.9304
CABG	212	31	14.2%	13.8%	1.0303
THA/TKA	992	46	4.6%	4.6%	1.0115

Indicates a mismatch between reported value and calculated value
Indicates a match between reported value and calculated value

Wonderful Hospital Center
Breakdown of Quality Measures Penalties
FFY 2018 Performance

2016 Medicare Operating Inpatient Payments $ 111,669,802

Readmission Measures

Measure		Excess Readmit Ratio	Total DRG Weight	Excess DRG Weight	Excess DRG Weight AS Percentage of Total	FY 2018 Prorated Incentive / (Penalty)	FY 2017 Prorated Incentive / (Penalty)
AMI	Acute Myocardial Infarction	0.9932	1,517.2445	0.0000	0.000%	$0	$0
HF	Heart Failure	1.0681	2,392.5335	162.9800	0.315%	($350,010)	($552,394)
PN	Pnuemonia	0.9304	2,017.5999	0.0000	0.000%	$0	($142,709)
COPD	Chronic Obstructive Pulmonary Disease	1.0074	964.5494	7.1043	0.014%	($15,257)	($8,736)
HK	Hip/Knee Arthroplasty	1.0115	2,111.3254	24.2566	0.047%	($52,092)	$0
CABG	Coronary Artery Bypass Graft	1.0303	964.2806	29.2523	0.056%	($62,821)	($157,317)
Net Total for Readmissions			51,807.4111	**223.5931**	**0.432%**	**($480,180)**	**($861,156)**
		Actual		Calculated			
Readmit Factor		0.9957		0.9957	= 1 - Excess DRG Weight / Total DRG Weight		
Readmit Penalty		-0.43%		-0.43%	= Readmit Factor - 1		

Value Based Purchasing Impact

		% Change	Dollarized Overall Impact
Linear Exchange Function	2.8908852		
Funding Adjustment (Flat percentage in legislation)		-2.00%	($2,233,396)
Incentive Payment (Earned back by performance)		2.340929%	$2,614,110
Net Adjustment		0.340929%	$380,714

Weighted Domain Scores	Score	Maximum Score	Funding Adjustment	Incentive Payment	FY 2018 Prorated Incentive / (Penalty)	FY 2017 Prorated Incentive / (Penalty)
Clinical Care Domain (Outcomes)	16.667	25.000	($558,349)	$1,076,082	$517,733	$535,541
Patient and Caregiver Centered Experience of Care/Care Coordination Domain	7.750	25.000	($558,349)	$500,378	($57,971)	$42,504
Safety Domain	13.571	25.000	($558,349)	$876,238	$317,889	($79,307)
Efficiency and Cost Reduction Domain	2.500	25.000	($558,349)	$161,412	($396,937)	($566,550)
Net Total for Value Based Purchasing	**40.488**	**100.000**	**($2,233,396)**	**$2,614,110**	**$380,714**	**($67,811)**

Note: FY 2017 Safety Domain includes Clinical Care Process Measures Subdomain performance

Wonderful Hospital Center			
Medicare Quality Measures Impact - Year-over-Year Impact			
	FFY 2018 Scores	**FFY 2017 Scores**	**Change**
2016 Medicare Operating Inpatient Payments	$ 111,669,802	$ 111,669,802	
2016 Medicare Total Inpatient Payments	$ 126,599,715	$ 126,599,715	
Readmission Penalty Factor	0.9957	0.9924	
Percent Impact to Operating Payments	-0.43%	-0.76%	
Readmissions Impact to Operating Payments	$ (480,180)	$ (848,690)	$ 368,510
Value Based Purchasing Factor	1.003409287	0.999401592	
Percent Impact to Operating Payments	0.34%	-0.06%	
VBP Impact to Operating Payments	$ 380,714	$ (66,824)	$ 447,539
HAC Penalty Indicator	N	Y	
HAC Penalty	0.00%	-1.00%	
VBP Impact to Operating Payments	$ -	$ (1,265,997)	$ 1,265,997
Total Impact	**$ (99,466)**	**$ (2,181,512)**	**$ 2,082,046**
Net Change to Total Inpatient Payments	**-0.08%**	**-1.72%**	
Note: Readmission Reduction Program and Value Based Purchasing is applied only to operating payments.			

Readmission Target	Excess Readmission Ratio	Before PN Expansion IPPS Operating Payments	Before PN Expansion Excessive Payments	After PN Expansion IPPS Operating Payments	After PN Expansion Excessive Payments
AMI	1.08	$6,000,000	$480,000	$6,000,000	$480,000
HF	0.99	$4,000,000	$0	$4,000,000	$0
PN	1.09	$3,500,000	$315,000	$5,000,000	$450,000
Others		$137,500,000		$136,000,000	
Total		$151,000,000	$795,000	$151,000,000	$930,000
Excess Pay as % Total			0.53%		0.62%

Expanded cohort leads to additional excessive payments despite Excess Readmission Ratio remaining constant.

Wonderful Hospital Center
Review of CMS Readmisson Data
Summary of Readmissions by Risk Factor

All readmission rates in this report are *Nominal Readmission Rates* (unadjusted for patient mix)

	AMI			COPD			HF			PN			CABG			THA/TKA		
Risk Factor	All Dischs	Re-admits	%	All Dischs	Re-admits	%	All Dischs	Re-admits	%	All Dischs	Re-admits	%	All Dischs	Re-admits	%	All Dischs	Re-admits	%
Overall	633	98	15%	826	174	21%	1,771	405	23%	1,476	217	15%	212	31	15%	992	46	5%
Acute Coronary Syndrome	125	27	22%	98	23	23%	365	102	28%	123	27	22%	N/A	0	0%	N/A	0	0%
Anterior Myocardial Infarction	48	10	21%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Chronic Obstructive Pulmonary Disease (COPD)	134	29	22%	N/A	0	0%	750	186	25%	574	106	18%	43	10	23%	106	9	8%
Chronic Pancreatitis	N/A	0	0%	10	3	30%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Congestive Heart Failure	193	38	20%	453	102	23%	1,364	341	25%	597	114	19%	46	8	17%	78	6	8%
Coronary Atherosclerosis or Angina	N/A	0	0%	501	119	24%	1,388	327	24%	818	120	15%	N/A	0	0%	266	20	8%
Decubitus Ulcer or Chronic Skin Ulcer	59	9	15%	126	48	38%	356	93	26%	281	57	20%	15	4	27%	44	3	7%
Dementia or Other Specified Brain Disorders	123	18	15%	191	40	21%	465	107	23%	660	110	17%	7	1	14%	30	1	3%
Diabetes Mellitus (DM) or DM Complications	272	46	17%	390	90	23%	913	233	26%	582	99	17%	105	20	19%	282	14	5%
Dialysis Status	22	7	32%	N/A	0	0%	90	29	32%	40	9	23%	3	1	33%	0	0	0%
Drug/Alcohol Abuse/ Dependence/Psychosis	N/A	0	0%	N/A	0	0%	120	40	33%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Drug/Alcohol Abuse/Dependence/Psychosis	N/A	0	0%	N/A	0	0%	N/A	0	0%	102	20	20%	N/A	0	0%	N/A	0	0%
Hemiplegia, Paraplegia, Paralysis, Functional Disability	24	4	17%	45	8	18%	115	33	29%	133	22	17%	13	1	8%	16	1	6%
History of Coronary Artery Bypass Graft (CABG) or Valve Surgery	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	11	4	36%	N/A	0	0%
History of Coronary Artery Bypass Graft (CABG) Surgery	90	13	14%	N/A	0	0%	446	111	25%	171	24	14%	N/A	0	0%	N/A	0	0%
History of Mechanical Ventilation	N/A	0	0%	152	36	24%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Lymphoma; Other Cancers	N/A	0	0%	N/A	0	0%	N/A	0	0%	298	58	19%	N/A	0	0%	N/A	0	0%
Major Psychiatric Disorders	N/A	0	0%	127	28	22%	233	60	26%	234	45	19%	12	2	17%	45	3	7%
Major Symptoms, Abnormalities	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	653	38	6%
Male	349	46	13%	N/A	0	0%	822	184	22%	758	121	16%	149	21	14%	344	19	6%
Metastatic Cancer or Acute Leukemia	14	2	14%	35	7	20%	50	16	32%	109	27	25%	N/A	0	0%	7	3	43%
Morbid Obesity; Other Endocrine/Metabolic/Nutritional Disorders	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	202	31	15%	N/A	0	0%
Nephritis	N/A	0	0%	N/A	0	0%	59	20	34%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Number of Procedures (two vs. one)	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	3	0	0%
Polyneuropathy; Other Neuropathies	N/A	0	0%	185	51	28%	N/A	0	0%	N/A	0	0%	35	6	17%	121	6	5%
Post Traumatic Osteoarthritis	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%	4	0	0%
Protein-Calorie Malnutrition	24	3	13%	72	22	31%	157	42	27%	227	53	23%	5	1	20%	4	0	0%
Provider ID of Readmitting Hospital [b]	N/A	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Renal Failure	180	42	23%	250	60	24%	1,007	268	27%	445	89	20%	55	16	29%	62	4	6%
Respirator Dependence/Respiratory Failure	N/A	0	0%	7	2	29%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Severe Hematological Disorders	N/A	0	0%	24	8	33%	79	24	30%	44	10	23%	2	0	0%	10	0	0%
Severe Infection; Other Infectious Diseases	265	47	18%	467	113	24%	N/A	0	0%	898	149	17%	N/A	0	0%	317	23	7%
Sleep Apnea	N/A	0	0%	153	29	19%	N/A	0	0%	N/A	0	0%	N/A	0	0%	N/A	0	0%
Stroke	49	7	14%	54	13	24%	198	57	29%	169	31	18%	21	5	24%	30	5	17%
Urinary Tract Infection	N/A	0	0%	N/A	0	0%	N/A	0	0%	490	82	17%	N/A	0	0%	N/A	0	0%
Valvular and Rheumatic Heart Disease	233	47	20%	N/A	0	0%	1,150	280	24%	458	79	17%	N/A	0	0%	N/A	0	0%
Vascular or Circulatory Disease	255	47	18%	474	106	22%	1,092	278	25%	799	134	17%	87	15	17%	277	17	6%
Vertebral Fractures Without Spinal Cord Injury	N/A	0	0%	64	27	42%	N/A	0	0%	86	12	14%	N/A	0	0%	N/A	0	0%

Readmission rate is over 40% (Minimum 10 discharges)
Readmission rate is over 30% (Minimum 10 discharges)

Institutional Roadblocks Readmissions

- Issues with patient population – our patients do not have financial/family support
- Placement problems
- Physician education/practices
- Observation status

- Your experiences……

Excess Days in Acute Care

- Excessive Days in Acute Care (EDAC) is used in Medicare Star Ratings that measures ED and Observation visits in addition to Inpatient Readmissions
  - Measure reported in # Excess day per 100 Discharges
  - Tracks 30 days post discharge
    - ED Visit = 0.5 Day
    - Observation = Tracked by hours rounded up to half day increments (e.g. 8 hours = 0.5 days, 20 hours = 1 day)
    - Readmissions based on LOS
    - No double counting based on date of service (e.g. ED and observation on same day, only observation counts)
    - Multiple visits do count, unlike readmission measure which is binary.
  - Future metric for Readmissions Penalty?

Revenue Defender Reporting

Two-Midnight Rule Medical Necessity

Sample Hospital

Distribution of Extended Observation and Inpatient Discharges to Home by MDC (Includes Medical AND Surgical Cases)

MDC	Description	Obs Cases 8-24 Hours	Obs Cases 25-36 Hours	Obs Cases 37+ Hours	Total Obs Cases	Average Hours in Obs	Total IP Cases	% of Cases in Obs
01	DISEASES & DISORDERS OF THE NERVOUS SYSTEM	41	22	80	143	91	503	22.14%
02	DISEASES & DISORDERS OF THE EYE	3	1	5	9	39	13	40.91%
03	DISEASES & DISORDERS OF THE EAR, NOSE, MOUTH & THROAT	12	9	25	46	42	44	51.11%
04	DISEASES & DISORDERS OF THE RESPIRATORY SYSTEM	25	12	32	69	38	799	7.95%
05	DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM	215	140	218	573	35	1,482	27.88%
06	DISEASES & DISORDERS OF THE DIGESTIVE SYSTEM	48	32	48	128	34	700	15.46%
07	DISEASES & DISORDERS OF THE HEPATOBILIARY SYSTEM & PANCREAS	4	2	7	13	38	170	7.10%
08	DISEASES & DISORDERS OF THE MUSCULOSKELETAL SYSTEM & CONN TISSUE	20	10	40	70	42	787	8.17%
09	DISEASES & DISORDERS OF THE SKIN, SUBCUTANEOUS TISSUE & BREAST	11	5	21	37	43	169	17.96%
10	ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES & DISORDERS	11	9	19	39	35	239	14.03%
11	DISEASES & DISORDERS OF THE KIDNEY & URINARY TRACT	18	8	24	50	37	497	9.14%
12	DISEASES & DISORDERS OF THE MALE REPRODUCTIVE SYSTEM	1	0	2	3	54	24	11.11%
13	DISEASES & DISORDERS OF THE FEMALE REPRODUCTIVE SYSTEM	0	0	1	1	83	21	4.55%
14	PREGNANCY, CHILDBIRTH & THE PUERPERIUM	0	0	0	0	0	0	0.00%

Institutional Roadblocks Readmissions

- Finance ultimately responsible for outcome, but not always involved in the process
- Areas of responsibility will talk about what can't be done not what can be done
- Access to timely data
- Ability to make the data actionable
- Dollarize improvement incrementally
- Can't fix everything, so address what you can

Hospital Value-Based Purchasing

- Key Reminders:
  - Revenue-neutral program for CMS
  - 2% operating payment reduction, then add back
  - Four domains

Hospital Value-Based Purchasing

Few changes in 2018

	FFY 2018	Measures
Safety	25%	CAUTI, CLABSI, *C. difficile*, MRSA, PSI-90, SSI ***(All duplicated with HAC)*** PC-01 (was an outcome measure)
Clinical Care – Outcomes	25%	Mortality (AMI, HF, PN)
Efficiency and cost reduction	25%	MSPB
Patient experience	25%	HCAHPS

Hospital Value-Based Purchasing

- Future eliminations

PROPOSED CHANGE

  - PSI-90 (FY 2019)
  - Condition-specific MSPB (FY 2019)
  - PC-01: Elective Delivery (FY 2021)
  - Healthcare-associated infections (HAIs) (FY 2021)
    - CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, MRSA, *Clostridium difficile*

Hospital Value-Based Purchasing

- Why not sooner? **PROPOSED CHANGE**
  - Justification of removal is that “costs associated with the measures outweigh the benefit of their continued use in the program”
    - PC-01 and HAI are chart abstracted and most data collected in 2018 will be applied to rates in 2020. Providers did the work to report, so CMS will use available data and “stop” further collection from CDC (hospital reporting will continue)
    - PSI-90 and MSPB are claims driven, so CMS will not run the calculations.

Hospital Value-Based Purchasing

- Safety Measures **PROPOSED CHANGE TO ELIMINATE DOMAIN 2021**
  - AHRQ Patient Safety Indicators (PSI) composite
  - CDC Central Line-Associated Blood Stream Infections (CLABSI)
  - CDC catheter-associated urinary tract infections (CAUTI)
  - Surgical Site Infection (SSI) for Colon and Abdominal Hysterectomy
  - C.Diff and MRSA
  - PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation (Only remaining Clinical Process of Care Measure)

Hospital Value-Based Purchasing

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Change in components for 2019
  - Removed Pain Management Questions
  - Added three-question Care Transition Measure

Hospital Value-Based Purchasing

- New questions– CTM-3:
  - The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
  - When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
  - When I left the hospital, I clearly understood the purpose for taking each of my medications.

Hospital Value-Based Purchasing

Signals of future HCAHPS differentiators

	Patient provided discharge instructions	"Strongly Agree" that patient understood instructions	"Strongly Agree" or "Agree" that patient understood instructions
Nation	87.00%	52.00%	94.00%
Florida	85.00%	50.00%	93.00%

Current HCAHPS methodology only counts questions if discharge information- not the level of understanding. “Understanding” of instructions currently not a factor.

Only “strongly agree” responses count for VBP scoring. If CTM-3 composite has scores like discharge planning comprehension, then CTM-3 could be differentiator in scoring results.

Hospital Value-Based Purchasing

- Pain management survey questions are changing starting January 2018, will be reflected in scoring in a few years.
- Old
  - During this hospital stay, did you need medicine for pain?
  - During this hospital stay, how often was your pain well controlled?
  - During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- New
  - During this hospital stay, did you have any pain?
  - During this hospital stay, how often did hospital staff talk with you about how much pain you had?
  - During this hospital stay, how often did hospital staff talk with you about how to treat your pain?

Hospital Value-Based Purchasing

- Clinical Outcomes Domain
  - Three 30-Day mortality measurements: AMI, HF & PN
  - FFY 2020
    - Complication Rate following Elective Primary Hip/Knee Arthroplasty
  - FFY 2021
    - Mortality for COPD
  - FFY 2022
    - Mortality for CABG

Hospital Value-Based Purchasing

- Efficiency and Cost Reduction Domain
  - Medicare Spend per episode per Beneficiary
    - 3 days prior to IP, plus 30 days post discharge
  - Reflects growing need to reduce spending on a per episode basis
    - Cost reduction via accountable care organizations and bundled payments are a priority for CMS. MSPB is a step towards making acute care hospitals responsible for total cost of care

Hospital Value-Based Purchasing

- Efficiency and Cost Reduction Domain
  - Standardized Medicare Spend Amount
    - Removes wage index, hospital specific factors
  - Average spend for each MDC, adjusted for MS-DRG, and then risk
- One score for all episodes
  - ~~Proposal for 2021: AMI & HF episodes~~

PROPOSED CHANGE TO ELIMINATE

Hospital Value-Based Purchasing

Spending by segment and provider type MSPB – 2016 Data	Florida Average Spending per Episode	Nation Average Spending per Episode
3 Days Prior to Admission	**$647**	**$688**
Inpatient Admission	**$10,946**	**$11,198**
Inpatient Hospital	$9,259	$9,676
Carrier (Professionals)	$1,668	$1,502
Others	$19	$20
30 Days Post Discharge	**$8,909**	**$8,415**
Home Health Agency	$857	$697
Hospice	$148	$122
Inpatient Hospital*	$2,761	$2,745
Outpatient	$549	$697
Skilled Nursing Facility	$3,248	$3,010
DME	$89	$85
Carrier (Professionals)	$,1257	$1,059
Total	**$20,502**	**$20,302**
*Includes LTACH, IRF, IPF		

Value Base Purchasing Outcomes

With data analysis, you can determine the distribution of outcomes. When the issues are across the house, data analysis allows you to pinpoint the highest value targets.

Value Base Purchasing Outcomes

Data analysis also enables you to identify issues that are concentrated – allowing you to focus on the underlying systemic causes.

Sample Hospital

Medicare Spending Per Beneficiary Analysis

Calendar Year 2014 Data

Verification of MSPB Measure

		From Table 3 of Hospital Specific Report		
	Calculated from CMS Data	Your Hospital	State	U.S.
Number of Eligible Admissions	3,606	3,606	185,162	5,446,136
Average Spending per Episode	$ 22,418.01	$ 22,418.01	$ 21,387.64	$ 20,024.64
MSPB Amount	$ 21,338.20	$ 21,338.19	$ 21,367.57	$ 19,679.19
US National Median MSPB	$ 20,017.29	$ 20,017.29	$ 20,017.29	$ 20,017.29
Average MSPB Measure	1.07	1.07	1.07	0.98

Sample Hospital

Medicare Spending Per Beneficiary Analysis

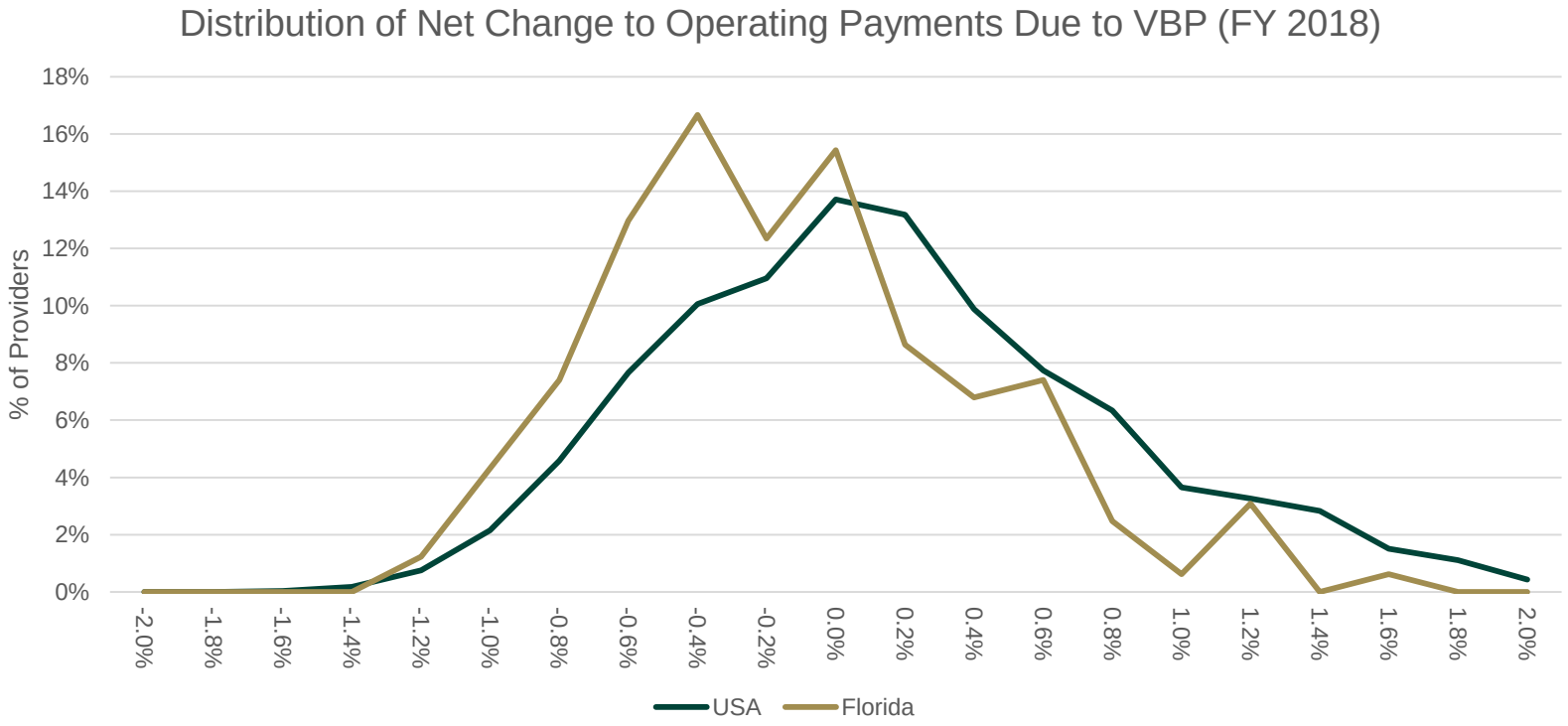
Calendar Year 2014 Data

Summary of Spending per MDC

							Per Episode			
MDC	Description	Episodes	Actual Payments	Standardized Payments	Renormalized Predicted Payments	Excess Spending	Actual Payments	Standardized Payments	Renormalized Predicted Payments	Excess Spending
0	Pre-MDC	7	$ 1,374,126	$ 1,132,329	$ 1,036,341	$ 95,988	$ 196,304	$ 161,761	$ 148,049	$ 13,713
1	Nervous System	339	$ 9,133,059	$ 7,425,438	$ 7,022,660	$ 402,779	$ 26,941	$ 21,904	$ 20,716	$ 1,188
6	Digestive System	430	$ 8,767,343	$ 6,986,424	$ 6,798,852	$ 187,572	$ 20,389	$ 16,247	$ 15,811	$ 436
7	Hepatobiliary System and Pancreas	72	$ 1,525,823	$ 1,192,697	$ 1,240,032	$ (47,335)	$ 21,192	$ 16,565	$ 17,223	$ (657)
8	Musculoskeletal System and Connective Tissue	590	$ 22,148,384	$ 17,911,955	$ 15,573,243	$ 2,338,713	$ 37,540	$ 30,359	$ 26,395	$ 3,964
9	Skin, Subcutaneous Tissue, and Breast	127	$ 2,781,148	$ 2,245,466	$ 2,030,802	$ 214,665	$ 21,899	$ 17,681	$ 15,991	$ 1,690
18	Infectious and Parasitic DDs	235	$ 7,645,959	$ 6,145,659	$ 6,134,281	$ 11,378	$ 32,536	$ 26,152	$ 26,103	$ 48
19	Mental Diseases and Disorders	63	$ 1,165,456	$ 935,995	$ 894,661	$ 41,334	$ 18,499	$ 14,857	$ 14,201	$ 656
20	Alcohol/Drug Use or Induced Mental Disorders	7	$ 77,600	$ 62,322	$ 85,747	$ (23,425)	$ 11,086	$ 8,903	$ 12,250	$ (3,346)
21	Injuries, Poison, and Toxic Effect of Drugs	43	$ 949,307	$ 762,496	$ 832,154	$ (69,658)	$ 22,077	$ 17,732	$ 19,352	$ (1,620)
22	Burns	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	Factors Influencing Health Status	5	$ 57,077	$ 45,860	$ 79,488	$ (33,628)	$ 11,415	$ 9,172	$ 15,898	$ (6,726)
24	Multiple Significant Trauma	2	$ 122,186	$ 98,436	$ 96,987	$ 1,450	$ 61,093	$ 49,218	$ 48,493	$ 725
25	Human Immunodeficiency Virus Infection	3	$ 174,053	$ 139,871	$ 118,913	$ 20,958	$ 58,018	$ 46,624	$ 39,638	$ 6,986
U	Ungroupable	23	$ 769,464	$ 617,444	$ 633,455	$ (16,011)	$ 33,455	$ 26,845	$ 27,542	$ (696)
Total		**3,606**	**$ 100,578,021**	**$ 80,839,341**	**$ 75,862,963**	**$ 4,976,378**	**$ 27,892**	**$ 22,418**	**$ 21,038**	**$ 1,380**

Sample Hospital
Medicare Spending Per Beneficiary Analysis
Calendar Year 2014 Data
Summary of Spending per MDC by Provider Type

				Standardized Payments by Provider Type						
MDC	Description	Episodes	Excess Spending	Inpatient	Outpatient	Physician	Skilled Nursing	Durable Medical Equipment	Home Health	Hospice
0	Pre-MDC	7	$ 95,988	$ 979,041	$ 11,467	$ 118,095	$ 23,677	$ 49	$ -	$ -
1	Nervous System	339	$ 402,779	$ 3,142,271	$ 268,443	$ 1,168,134	$ 2,582,170	$ 22,178	$ 228,326	$ 13,917
6	Digestive System	430	$ 187,572	$ 3,763,568	$ 259,320	$ 1,338,291	$ 1,345,349	$ 23,736	$ 214,382	$ 41,778
7	Hepatobiliary System and Pancreas	72	$ (47,335)	$ 711,634	$ 26,721	$ 226,612	$ 186,063	$ 2,774	$ 29,718	$ 9,176
8	Musculoskeletal System and Connective Tissue	590	$ 2,338,713	$ 8,597,192	$ 304,673	$ 2,483,792	$ 5,926,015	$ 45,664	$ 542,711	$ 11,908
9	Skin, Subcutaneous Tissue, and Breast	127	$ 214,665	$ 966,526	$ 89,542	$ 340,410	$ 731,928	$ 8,836	$ 102,205	$ 6,019
18	Infectious and Parasitic DDs	235	$ 11,378	$ 3,125,637	$ 321,667	$ 960,231	$ 1,536,868	$ 16,584	$ 139,927	$ 44,744
19	Mental Diseases and Disorders	63	$ 41,334	$ 536,386	$ 39,334	$ 167,459	$ 176,902	$ 2,399	$ 12,138	$ 1,376
20	Alcohol/Drug Use or Induced Mental Disorders	7	$ (23,425)	$ 45,988	$ 4,927	$ 10,804	$ -	$ 109	$ 493	$ -
21	Injuries, Poison, and Toxic Effect of Drugs	43	$ (69,658)	$ 414,446	$ 49,234	$ 140,421	$ 137,410	$ 4,502	$ 16,484	$ -
22	Burns	0	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23	Factors Influencing Health Status	5	$ (33,628)	$ 22,213	$ 6,264	$ 13,084	$ -	$ 477	$ 3,821	$ -
24	Multiple Significant Trauma	2	$ 1,450	$ 47,021	$ 1,523	$ 12,111	$ 37,518	$ 264	$ -	$ -
25	Human Immunodeficiency Virus Infection	3	$ 20,958	$ 67,258	$ 4,350	$ 12,633	$ 55,218	$ 411	$ -	$ -
U	Ungroupable	23	$ (16,011)	$ 360,460	$ 32,523	$ 119,003	$ 68,492	$ 4,195	$ 25,278	$ 7,494
Total		**1,946**	**$ 3,124,778**	**$ 22,779,641**	**$ 1,419,988**	**$ 7,111,079**	**$ 12,807,611**	**$ 132,180**	**$ 1,315,480**	**$ 136,415**


Distribution of Net Change to Operating Payments Due to VBP (FY 2018)
% of Providers
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
-2.0%
-1.8%
-1.6%
-1.4%
-1.2%
-1.0%
-0.8%
-0.6%
-0.4%
-0.2%
0.0%
0.2%
0.4%
0.6%
0.8%
1.0%
1.2%
1.4%
1.6%
1.8%
2.0%
USA
Florida

Institutional Roadblocks Value Based Purchasing

- Measures too big to control
- Lack of control – non-acute services
  - Selection of institution
  - Control over cost
- Inability to focus, unaware of where focus needs to be
- Your experiences……

Institutional Roadblocks Value Based Purchasing

- Finance ultimately responsible for outcome, but not always involved in the process
- Areas of responsibility will talk about what can't be done not what can be done
- Access to timely data
- Ability to make the data actionable
- Dollarize improvement incrementally
- Can't fix everything, so address what you can

Hospital-Acquired Conditions

- 1% reduction in payment for hospitals in the top quartile. This is an all-or-nothing penalty.
- Measures
  - 15% PSI-90
  - 85% CLABSI, CAUTI, SSI, MRSA, C. Diff

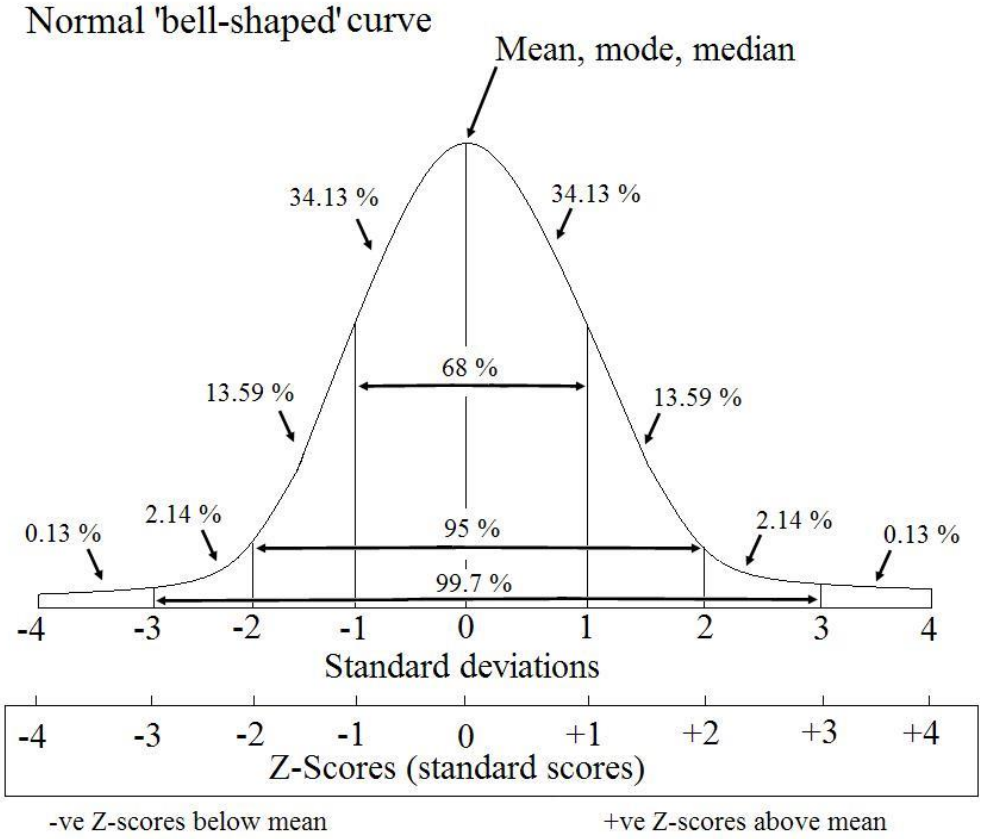
Wonderful Hospital Center

Medicare Quality Measures Impact - Year-over-Year Impact

	FFY 2018 Scores	FFY 2017 Scores	Change
2016 Medicare Operating Inpatient Payments	$ 111,669,802	$ 111,669,802	
2016 Medicare Total Inpatient Payments	$ 126,599,715	$ 126,599,715	
Readmission Penalty Factor	0.9957	0.9924	
Percent Impact to Operating Payments	-0.43%	-0.76%	
Readmissions Impact to Operating Payments	$ (480,180)	$ (848,690)	$ 368,510
Value Based Purchasing Factor	1.003409287	0.999401592	
Percent Impact to Operating Payments	0.34%	-0.06%	
VBP Impact to Operating Payments	$ 380,714	$ (66,824)	$ 447,539
HAC Penalty Indicator	N	Y	
HAC Penalty	0.00%	-1.00%	
VBP Impact to Operating Payments	$ -	$ (1,265,997)	$ 1,265,997
Total Impact	**$ (99,466)**	**$ (2,181,512)**	**$ 2,082,046**
Net Change to Total Inpatient Payments	**-0.08%**	**-1.72%**	

Note: Readmission Reduction Program and Value Based Purchasing is applied only to operating payments.

Hospital-Acquired Conditions



Hospital-Acquired Conditions

	Has HAC Penalty	NO HAC Penalty
Nationwide	23.04%	76.96%
Florida	27.49%	72.51%

Institutional Roadblocks Hospital Acquired Conditions

- Finance ultimately responsible for outcome, but not always involved in the process
- Areas of responsibility will talk about what can't be done not what can be done
- Access to timely data
- Ability to make the data actionable
- Dollarize improvement incrementally
- Can't fix everything, so address what you can

Strategy Checklist

- Identify and focus on what is achievable
- Set achievable goals
- Collect/compare data
- Measure impact of interventions
- Ensure participation in quality initiative committees
- Review data flows to tie issues across quality measures

Thank You!

Questions??

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