Value Based Purchasing and Accountable Care Organizations

PRESENTED BY:

Mary Carol Todd, MSN, RN
Senior Vice President, Clinical Efficiency
Catholic Healthcare West
San Francisco, California

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CHW

CHW History

- CHW was founded in 1986 - Sisters of Mercy Burlingame Regional Community and the Sisters of Mercy Auburn Regional Community merged their health care ministries.
  - to enhance their charitable capabilities,
  - expand the Catholic health care ministry,
  - promote social justice.
- Since 1986, other congregations and their health care ministries, as well as non-Catholic community hospitals have joined Catholic Healthcare West.
  - Sisters of St. Dominic - Adrian, Michigan
  - Sisters of Charity of the Incarnate Word - Houston, Texas
  - Dominican Sisters - San Rafael, California
  - Dominican Sisters - Kenosha, Wisconsin
  - Sisters of St. Francis of Penance and Christian Charity - Redwood City, California.

Catholic Healthcare West

- Fifth largest health care system in the United States
  - 155 Care Sites – Hospitals, Surgery Centers, Urgent Care, Home Health, Laboratories, Clinics, Physician Practices
  - 10,000 Affiliated Physicians
  - 55,000 Employees
  - $13 Billion in Assets
  - Provide $985 Million in Community Benefit
  - 4 Health Insurance Companies with over 500,000 Members


Nevada
California
Arizon
Hospitals


Nevada
California
Arizona
Ambulatory/Surgery


Nevada
California
Arizona
Home Health


Nevada
California
Arizona
Specialty

Topics/Agenda

- CHW Care Management Priorities
- Value Based Purchasing
  - Background
  - CHW Preparation and Monitoring
- Readmissions
- Accountable Care Organizations
  - United States Current High Level Plan
  - CHW Pilot Project with Commercially Insured Patients

Current CHW Care Management Priorities

- Quality
  - CMS Core Measures
  - Value Based Purchasing
  - Reduction of Hospital Acquired Conditions
- Patient Safety
  - Perinatal Safety
  - Surgical Safety
  - Emergency Department
- Patient Experience
  - HCAHPS
- Clinical Efficiency
  - CMS Readmissions
  - Length of Stay
  - Denials – Recovery Audit Contractors
  - Cost per Case – Clinical Variation

Value Based Purchasing

- Current CMS VBP implementation
- Outcome measures in use by CMS
- CMS 30 day mortality measures
- CMS 30 day re-admission measures

CMS Purpose

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: measurement, payment incentives, public reporting, conditions of participation, coverage policy, QIO program
  - Initiatives: pay for reporting, pay for performance, gainsharing, competitive bidding, coverage decisions, direct provider support

Support for VBP

- President's Budget - FYs 2006-09
- Congressional Interest in P4P
- MedPAC Reports to Congress - P4P recommendations related to quality, efficiency, health information technology, and payment reform
- IOM Reports - P4P recommendations in To Err Is Human and Crossing the Quality Chasm Report, Rewarding Provider Performance: Aligning Incentives in Medicare
- Private Sector
  - Private health plans
  - Employer coalitions

VBP Demos and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay-for-Performance Demonstration
- ESRD Bundled Payment Demonstration
- ESRD Disease Management Demonstration
- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration

VBP Initiatives

- **Hospital Pay for Reporting: Inpatient & Outpatient**
  - **RHQDAPU & HOP QDRP**
- **Hospital VBP Plan & Report to Congress**
- **Hospital-Acquired Conditions & Present on Admission Indicator**
- Physician Quality Reporting Initiative
- Physician Resource Use Confidential Reports
- **Home Health Care Pay for Reporting**
- Ambulatory Surgical Centers Pay for Reporting
- ESRD Pay for Performance

Measures for VBP

- Various measure types used – benefits and limitations
  - Process
    - Most available but may become "topped out"
    - Focus on specific but limited set of processes that impact outcomes
  - Outcome
    - Less available but broader in scope, less subject to become "topped out"
  - Experience of Care
    - May relate to processes or outcomes
  - Structural

Outcomes Measures in Use by CMS

- Measure Summary: 74 total current CMS outcome measures in use (approximately)
  - 28 Inpatient (including QIO)
  - 8 Physician
  - 12 Home Health
  - 14 Nursing Home
  - 4 ESRD
  - 8 Medicare Advantage

Hospital Outcome Measures: Mortality, Complications, Readmissions (RHQDAPU & QIO)

- Mortality (Medical Conditions)
  - 30 day mortality AMI, HF, PNE, (CMS) *
  - Selected Medical Conditions (AHRQ) *
- Mortality (Surgical Conditions/Procedures)
  - AAA, Hip Fractures (AHRQ) *
  - Selected Surgical Conditions (AHRQ) *
  - Death of surgical patients with treatable serious complications*
  - Complication/patient safety for selected indicators *
- Complications (Medical and Surgical)
  - Post op wound dehiscence in abdominal-pelvic surgery *
  - Accidental puncture or laceration *
  - Iatrogenic pneumothorax *
  - MRSA Infection Rate; Transmission Rate (CMS-QIO)
  - Hospital Acquired Pressure Ulcers (CMS-QIO)
- Readmission (Medical Conditions)
  - AMI, HF, PNE (CMS) *
  - All patient Readmission Rate (CMS-QIO)
- Intermediate Outcome
  - Cardiac Surgery Patient Controlled 6 AM Glucose

Hospital Acquired Conditions: Background

- The Deficit Reduction Act (DRA) of 2005 requires the Secretary to identify conditions that are:
  - (a) high cost and/or high volume
  - (b) result in the assignment to a higher weighted DRG and
  - (c) could reasonably have been prevented through the application of evidence-based guidelines
- Beginning October 1, 2008, Medicare no longer paid hospitals at a higher rate for the increased costs of care that result when a patient is harmed by one of the listed conditions if it was hospital-acquired.
- Medicare continues to assign a discharge to a higher paying MS–DRG if the selected condition is present on admission (POA).
- The POA indicator reporting requirement and the HAC payment provision apply to IPPS hospitals only.

Hospital Acquired Conditions

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burns
  - Electric Shock
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis or Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection

Surgical Complications

- Surgical Site Infection Following:
  - Coronary Artery Bypass Graft (CABG)—Mediastinitis
  - Bariatric Surgery
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
  - Total Knee Replacement
  - Hip Replacement

HAC – Predicting and Tracking Financial Impact

Group: Catholic Healthcare West

CMS Hospital Acquired Conditions Financial Predictor

All Inpatients

Starting from Quarter 1 2010 thru Quarter 4 2010

Note: 99.6% of your inpatient discharges for this time period contain known POA/NPOA diagnosis status coding. This report is limited to those discharges.

CMS Hospital Acquired Conditions Financial Predictor ?

Hospital multiplier used in calculations	$6,500

Report Summary

Total discharges with reduced MS DRG assignments during this reporting period:	59
Total number of conditions impacting MS DRG assignments during this reporting period:	59
Total dollars potentially lost due to non-reimbursable conditions not present on admission:	$431,881

Report Details on Each Condition Listed Below

Air Embolism

Total number of discharges with this condition not present on admission:	1
Total number of discharges with reduced MS DRG assignment:	0
Total Dollars Lost to this condition:	$0

Blood Incompatibility

Total number of discharges with this condition not present on admission:	1

Hospital Acquired Conditions: Projected Costs Savings

- Savings estimates for the next 5 fiscal years are shown below:
- Year Savings (in millions)
  - FY 2009 $21
  - FY 2010 $21
  - FY 2011 $21
  - FY 2012 $22
  - FY 2013 $22

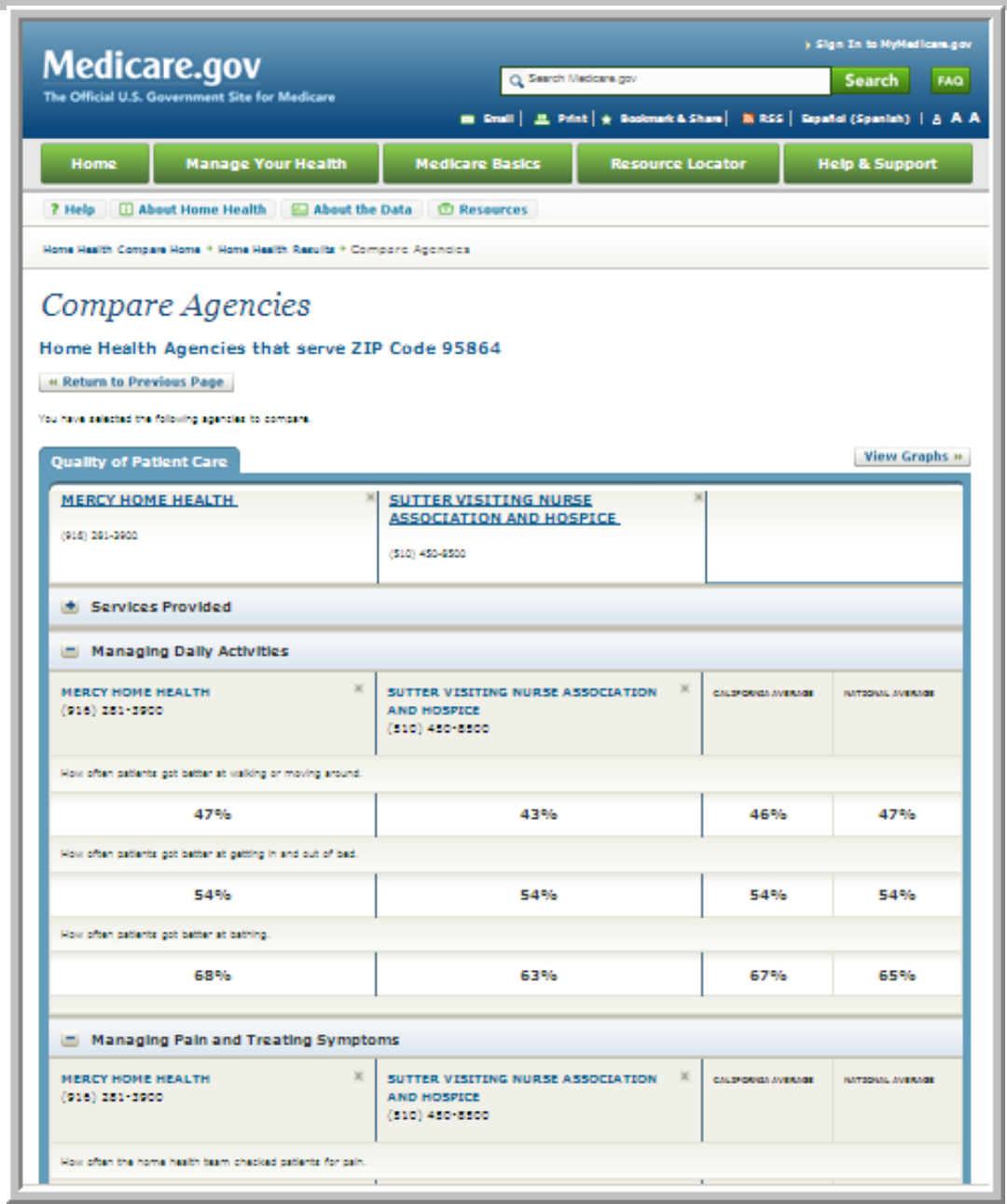
National Coverage Determination—Hospitals and Physicians

- No coverage for
  - Surgery on wrong body part
  - Surgery on wrong patient
  - Wrong surgery on a patient
- Not reasonable and necessary
  - Kyphoplasty
  - Implantable Cardiac Defibrillators

Home Health Outcome Measures

- Management of Care
  - Acute Care Hospitalization
  - Emergent Care (risk adjusted)
  - Discharge to Community
- Improvement in functional status
  - Ambulation /locomotion
  - Bathing
  - Bed transferring
  - Dyspnea
- Medication Management
  - Management of Oral Medication
- Pain
  - Improvement in pain interfering with activity
- Surgical Wounds
  - Improvement in status of surgical wounds
- Complications
  - Emergency Care for Wound Infections, Deteriorating Wound Status
- Incontinence
  - Improvement in Urinary Incontinence

CMS - Home Health Compare



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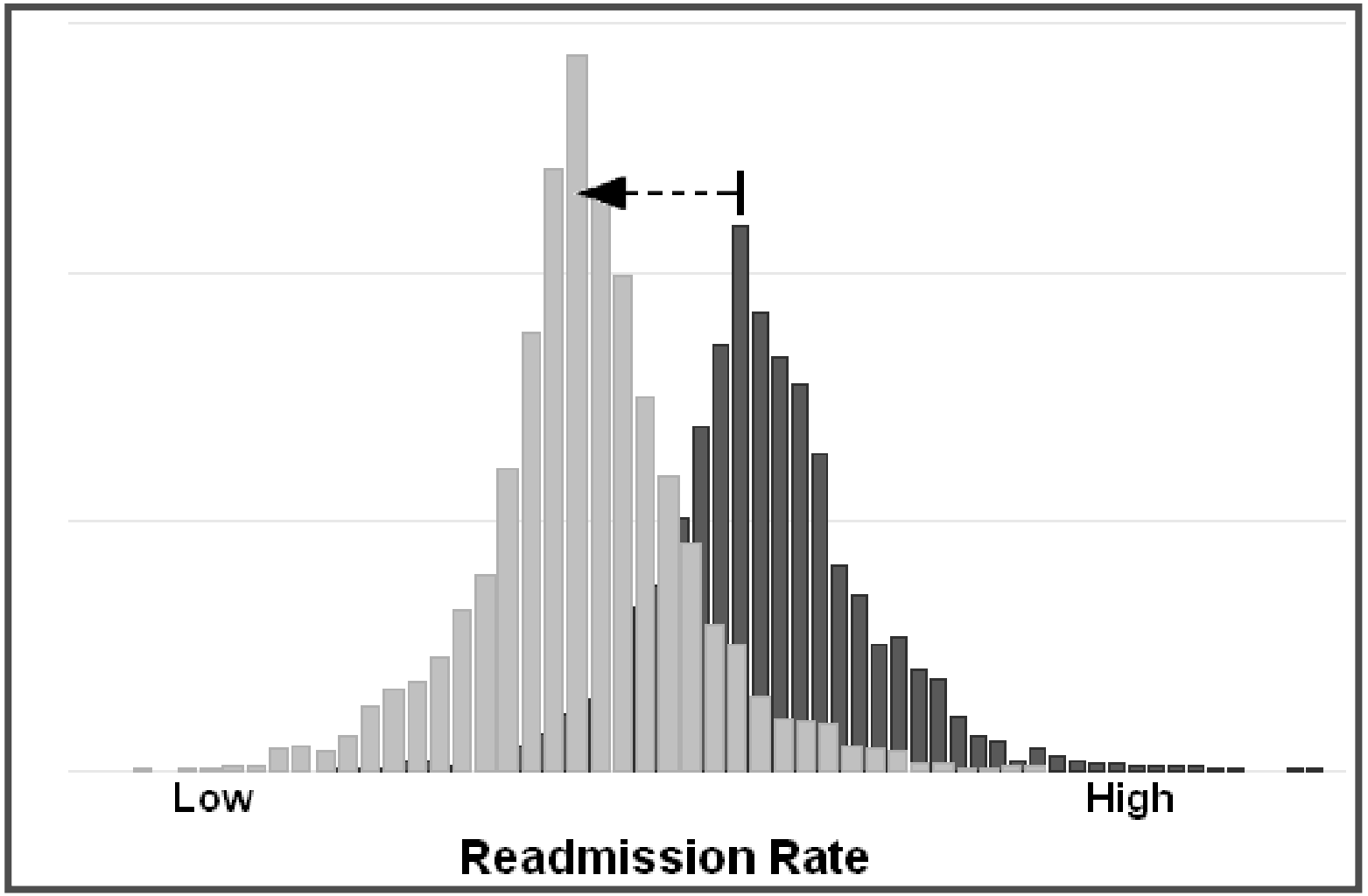
Readmissions are…

- Frequent
  - 20% of Medicare beneficiaries were readmitted within 30 days
- Costly
  - Account for $15 Billion in Medicare annual spending
  - CMS 10 year savings - $26 billion by reducing readmissions
  - In 2013 hospitals with readmission rates above a certain threshold have payments for the original hospitalization reduced by 20 percent (Baucus Bill)
- Avoidable
  - 76% of Medicare readmissions were “potentially avoidable”
- Can be improved
  - Research and quality improvement initiatives have demonstrated at least a 30% reduction in readmissions for various patient populations

CMS' ultimate goal is to shift the curve



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CHW Acute Care Readmission Rate Indicator Definition

Objective	Reduce the incidence of acute care rehospitalization within 30 days for patients with Pneumonia, Heart Failure and AMI
Measurement	Percentage of non-elective readmissions to the any CHW hospital for Medicare patients treated during the antecedent admission for Pneumonia, Heart Failure or Acute Myocardial Infarction from DataVision
Rationale	Rehospitalization within 30 days frequently results from failure in safely transitioning patients to the outpatient setting and is a focus for CMS to improve the care for Medicare beneficiaries and could result in payment deductions starting in 2013
System Goals	Baseline: Threshold: 5% Reduction Target: 10% Reduction Stretch: 15% Reduction
Hospital Goals	FY11 (year one) targets will be hospital specific FY12 and 13 All hospitals measured against a single standard
Final Assessment	July - May FY13

CHW Hospitals FY12 Actions

- Set Individual Hospital Targets
- Actions
  - Teachback –assure implementation – observe regularly
  - Select Model by July 31
  - Q1 – Hospital - Implement
    - Submit model, implementation plans and present
    - Conduct patient/family readmission interviews and submit to Q-Tube
    - System – Complete Midas Focus Study to record readmission reviews and capture patient interview results
  - Q2 – System - Establish workgroups specific to model chosen
  - Q3 – Tune –up education on models
  - Q4 – Reduce readmissions and identify leading practices

Questions/Frage?

ACOs Defined

Core Elements of the Medicare ACO Did Not Change from ACA

Providers	Organization Requirements	Patients

• Primary care centric
• Can include:
  • Advanced Practices RNs
  • Specialists
  • Hospitals
  • Post-Acute Care
• Receive Part A & B FFS payments
	• Must have a TIN in operating state
	• Does not need to have its own provider ID
		• At least 5,000 beneficiaries
		• Assigned retrospectively based on primary care
		• Aren't "locked-in"
		• Must be notified of ACO participation

Becoming an ACO

Potential ACOs Must Apply and Provide Documentation Supporting the Organization's Ability to Manage Population Health

The Application Must Include Documents Outlining:

- Participant agreements or employment agreements describing ACO participants' rights and obligations in the ACO
  - *Includes how shared savings are to be distributed*
- Scope and scale of the quality and clinical integration program
- Organizational and management structure
- A board-certified medical director
- Information regarding all of the ACO participants
- How the ACO will achieve "patient centeredness
- How the ACO's governing body adheres to structural requirement
- And other documents as requested (i.e. bylaws, financial stmts, remedial process for participant non-compliance)

Quality Metrics

ACOs Have to Report 65 Metrics Across Five Domains

Doman	Category	CMS Table 1 Measures (Total)
1. Patient/Caregiver Experience		1 – 7 (7 Measures)
2. Care Coordination		8 – 23 (16 Measures)
3. Patient Safety		24 – 25 (2 Measures)
4. Preventive Health		26 – 34 (9 Measures)
5. At Risk Population/Frail Elderly Health	Diabetes	35 – 65 (31 Measures)
	Heart Failure	
	Coronary Artery Disease	
	Hypertension	
	COPD	
	Frail Elderly	

Quality Metrics

Example Quality Score for an ACO in the Second Performance Year

Domain	# of Measures	Potential Points[1]	Example ACO Score	% Possible Points[2]
Patient/Caregiver Experience	7	14	13	92.9%
Care Coordination	16	32	25	78.1%
Patient Safety	2	4	3	75.0%
Preventive Health	9	18	17	94.4%
At-Risk Population/Frail Elderly Health	31	62	55	88.7%
Total	65	130	113	
Overall Quality Score[3]				85.8%
Track One ACO (50% Possible) Allowable Savings Percentage[4]:				**42.9%**

Notes:

1. Each measure is worth 2 points and is used to calculate the "potential points" for the domains (i.e. Patient Caregiver Experience has 14 possible points - 7 measures X 2 points per measure)
2. A percentage score is calculated for each domain by dividing the actual points the ACO received by the potential points it could have received (i.e. Example ACO received 92.9% Patient Caregiver Experience – 13 actual points/14 possible points)
3. The possible points are equally weighted for each domain and averaged together to develop an overall quality score
4. The allowable shared savings percentage is calculated by multiplying the overall quality score by the track specific maximum shared savings percentage (i.e. Track One ACO 50% X 85.8% = 42.9%)

Payment Mechanism

CMS Is Offering Two Reimbursement "Tracks"

Track 1:

One-sided risk model: shares savings only for the first two years and shares savings and losses in the third year

- Shares savings 50/50 with Medicare
- Must exceed a minimum savings ratio based on beneficiary population

Track 2:

Two-sided risk model: Shares savings and losses for all three years

- Shares savings 60/40 with Medicare
- Must exceed 2% threshold

Data Sharing

CMS Will Provide ACOs with Data to Help Manage Performance

Quarterly Aggregate Reports:

Will be based on previous 12 months of data and include:

- Financial performance
- Quality performance scores
- Aggregated metrics on the assigned beneficiary population
- Utilization by Subpopulation

Monthly Claims Level Data:

Can request a standardized dataset:

- Procedure codes
- Diagnosis codes
- Dates of service
- Provider/supplier ID
- Part D data

A Community “ACO” Model - Case Study

in the past decade, California HMO rates have increased on average 11% per year

if we manage to reduce that trend to 8% in the next decade, prices will double by 2020. . .

. . . and our Access +HMO family rate for CalPERS members will be nearly $39,000 per year

we believe this will not happen: either the private sector will solve this issue or it will be solved for us

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Employers in US can hardly afford today's rates

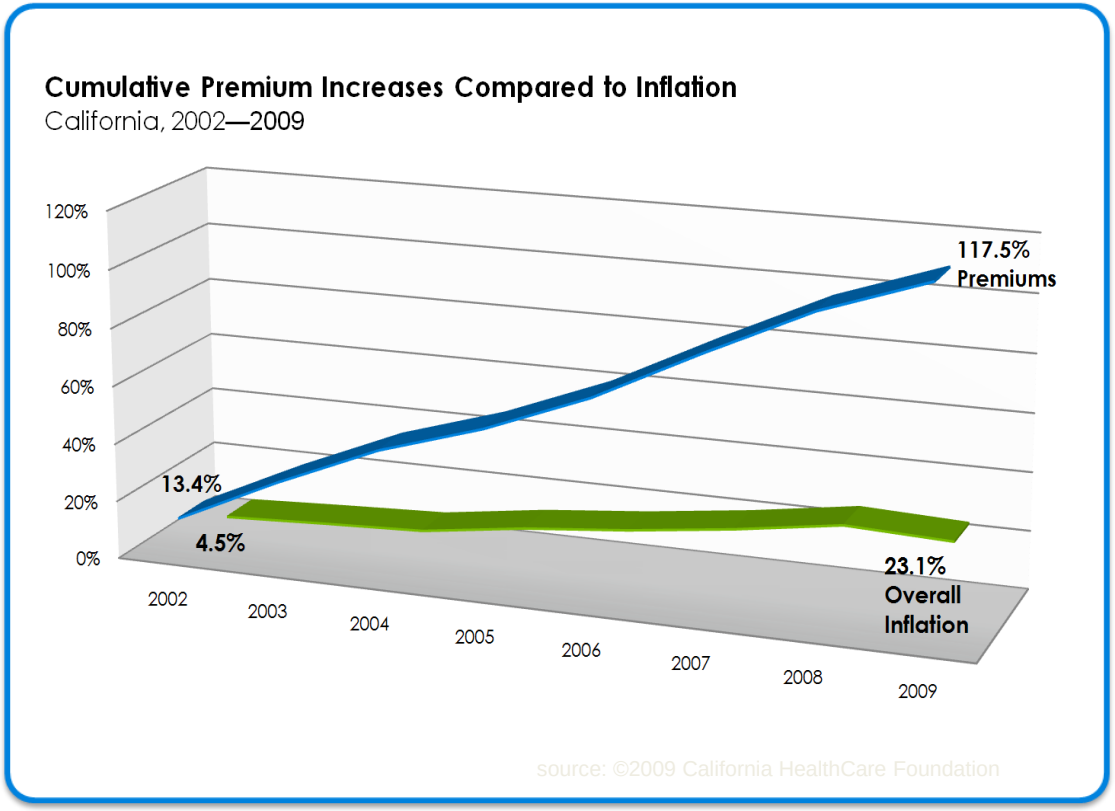
- **It costs less to hire a software engineer in India than it does to pay for the health benefits of a software engineer in Silicon Valley**
  - *—Blue Shield Analysis (after conversation with Venture Capitalist)*

- **"Wow, we're paying almost twice in health care costs as what we're making in earnings…"**
  —Steve Burd, CEO of Safeway, The New York Times, November 29, 2009

- **(The company now spends) "almost as much on health care for our partners as we do on the green coffee we buy."**
  - *—Howard Schultz, CEO of Starbucks Corp, Thomson Reuters, July 27, 2009*

- **"G.M. has to address how a company that lost more than $20 billion last year can afford $5 billion a year in medical bills. G.M's future obligations for retiree health care are estimated at $47 billion, and by next year it is required by its contract to contribute more than $10 billion to the trust set up in 2007."**
  —The New York Times, February 17, 2009

Trends threaten long-term viability of private health insurance



In 2020, $39,000 could …

- purchase a CalPERS, Access+ HMO family insurance policy from Blue Shield
- buy 6 years of a household's groceries
- be 1.6 times higher than the median income for BRIC counties
- buy the newest version of a Toyota Prius

Source: Premium forecasts based upon standard plan manual premium PPO annual increase of 10.3% from the Milliman Group Health Insurance Survey 2008 & Commonwealth Fund California premium data of $12,254 in 2008, "Paying the Price: How Health Insurance Premiums are Eating up Middle-Class Incomes" August 2009. 2020 forecasted median CA household income from IHS Global Insight, annual household food expenditures from the National statistical offices/OECD/Eurostat/Euromonitor International, BRIC & World annual gross income projections [illegible] national statistics, Prius pricing from April 2010 Consumer reports ($26,750 with assumed 3% trend per year over 10 years)

What drives cost?

member

- age
- behavior

healthcare coverage

political choices

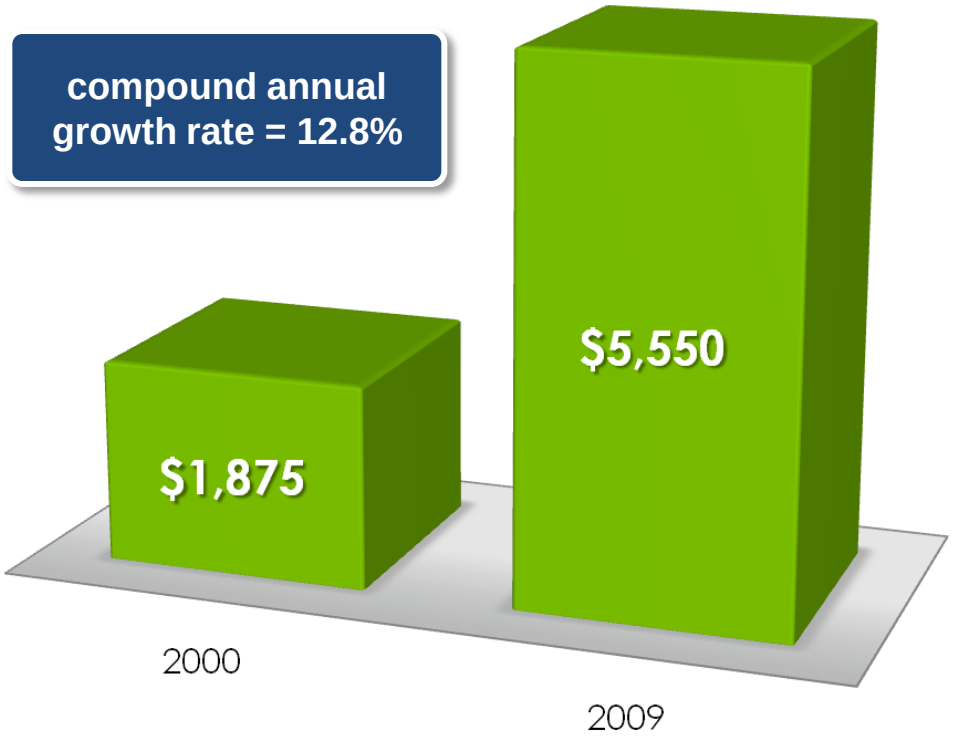
cost and quality of health care

provider

- Unit costs

What drives costs (continued)?

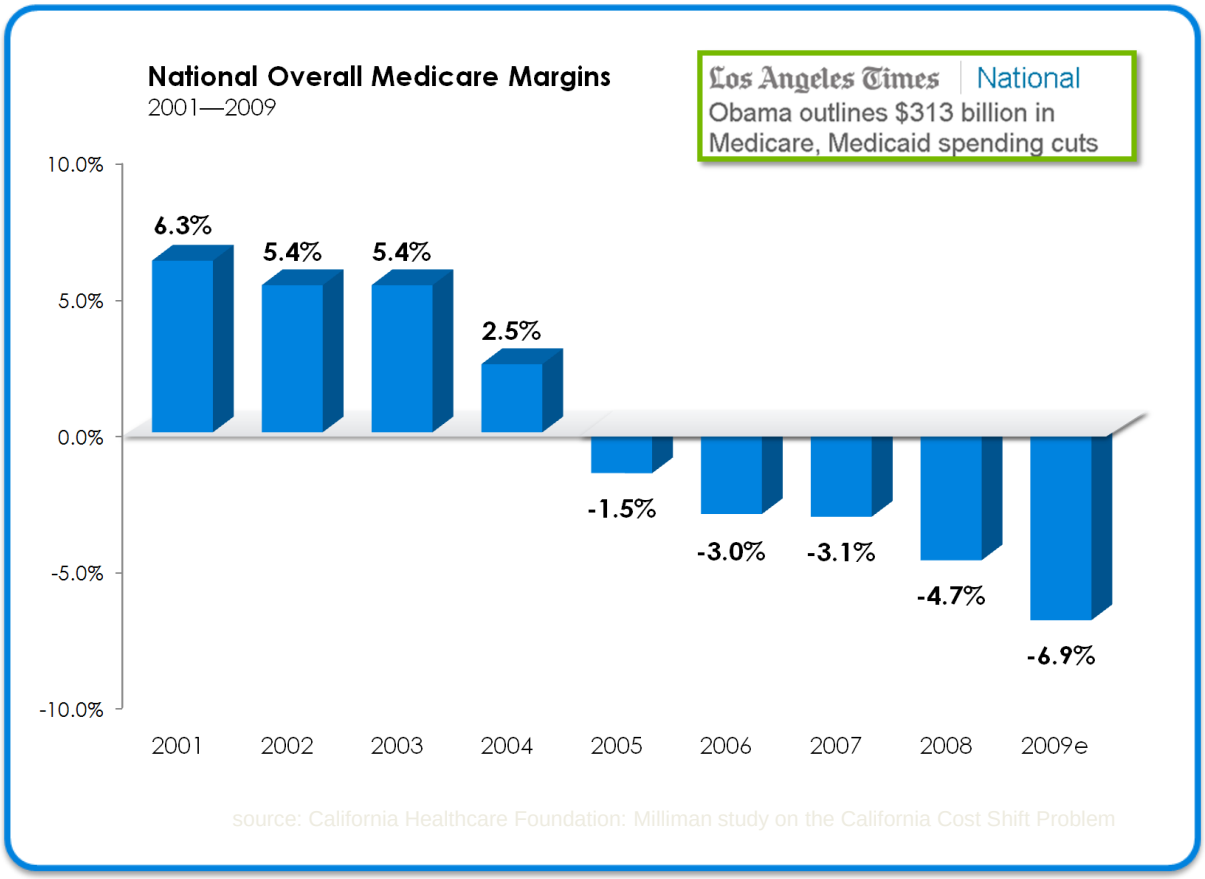
average cost per acute inpatient bed day in California



What drives costs (continued)?

Hospital Costs/Profits

- nearly $10 billion in under reimbursement from medicare and medicaid in CA
- increasing number of uninsured
- infrastructure upgrades
- nurse staffing ratios
- costs of new technologies



THE WALL STREET JOURNAL. | POLITICS

JANUARY 28, 2009

States Take Aim At Medicaid

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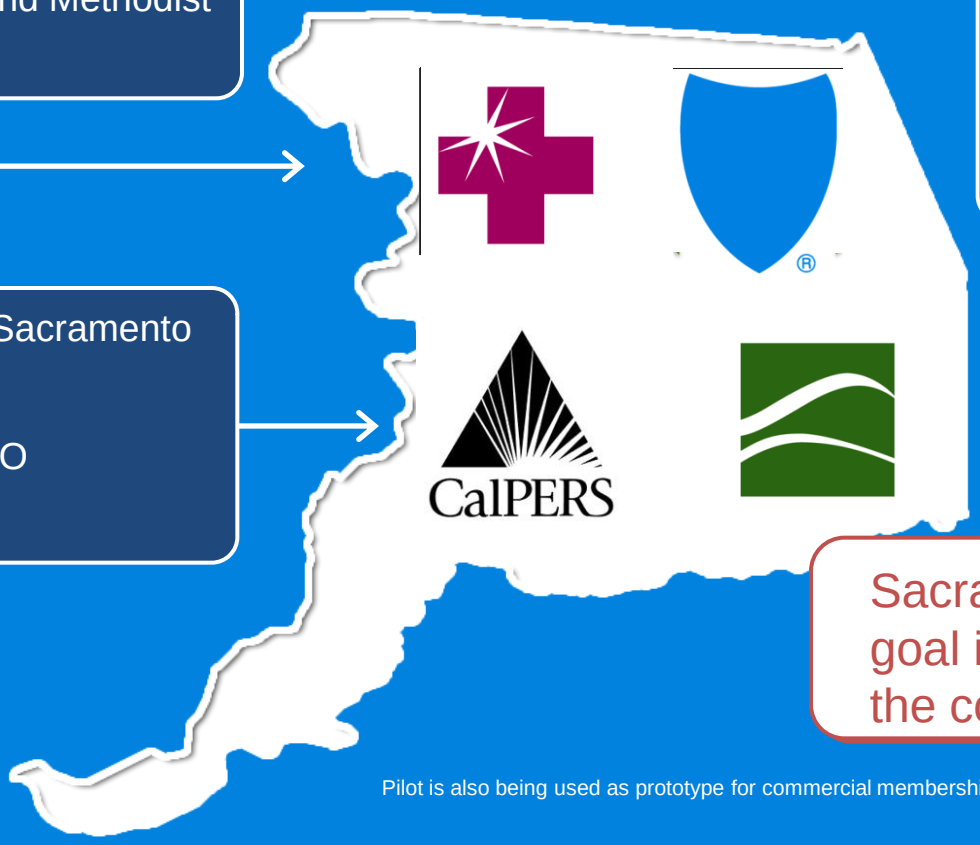
Why Sacramento – location of pilot project?

4 hospitals in Sacramento County including Mercy General, Mercy San Juan, Mercy Folsom, and Methodist Sacramento

- 207,000 total Sacramento members
- 90% in an HMO

Sacramento market



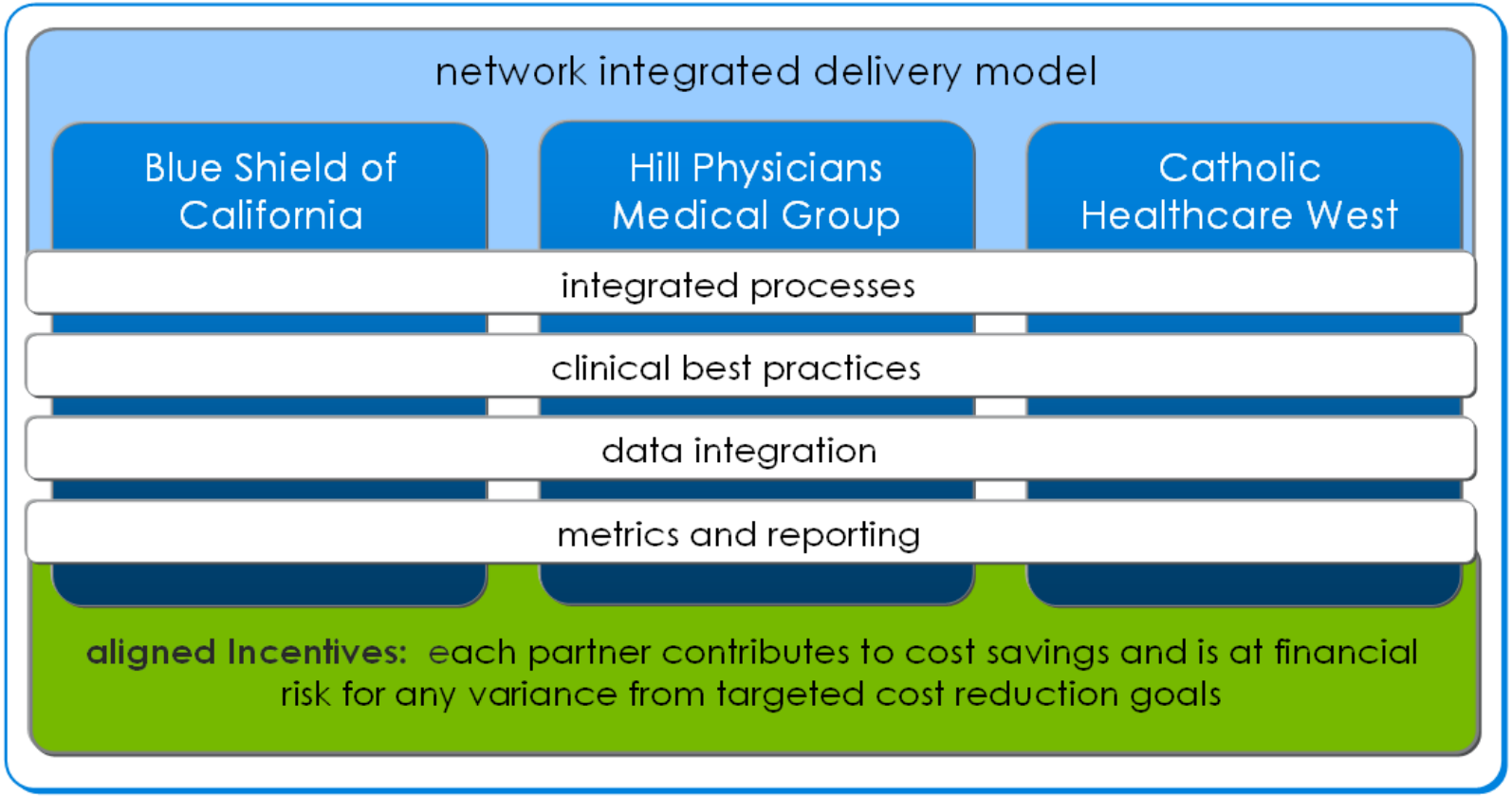
- ~ 520 MDs in Sacramento County
- ~ 38,000 CalPERS members
- 1,000 member growth in 2010

Sacramento pilot goal is to reduce the cost trend ~10%

Pilot is also being used as prototype for commercial membership with intent to scale model to other segments.

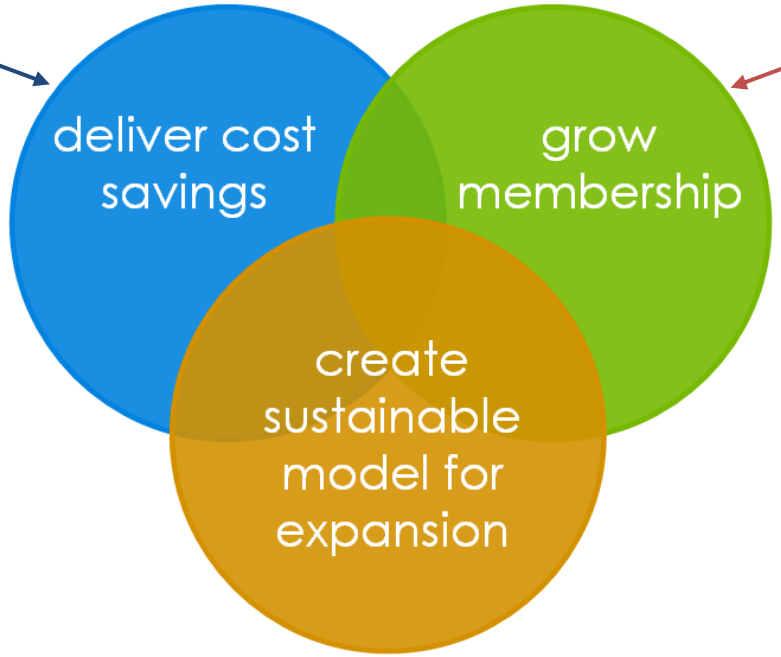
Collaboration Between Partners Necessary

- develop an integrated delivery model
- provide coordinated care
- improve quality outcomes
- drive out cost



Result-oriented goals

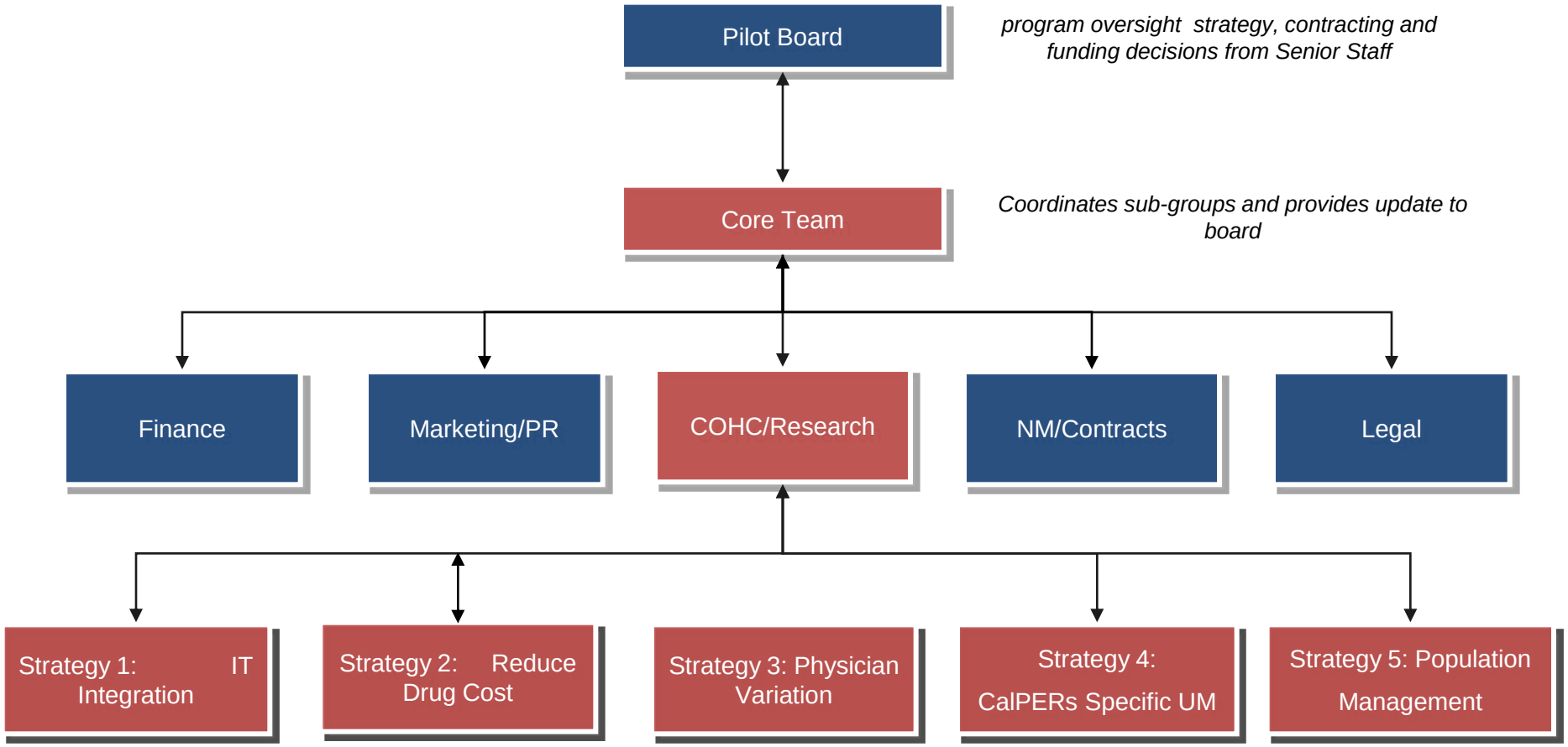
reduce cost of healthcare trend to 0% in aggregate for members in the pilot



increase enrollment in NetValue as a means to gain market share for partners

develop way to work together that aligns parties to drive continuous improvement (cost, quality, service) and allows for expansion to other geographic areas

Team approach – Structure of Pilot



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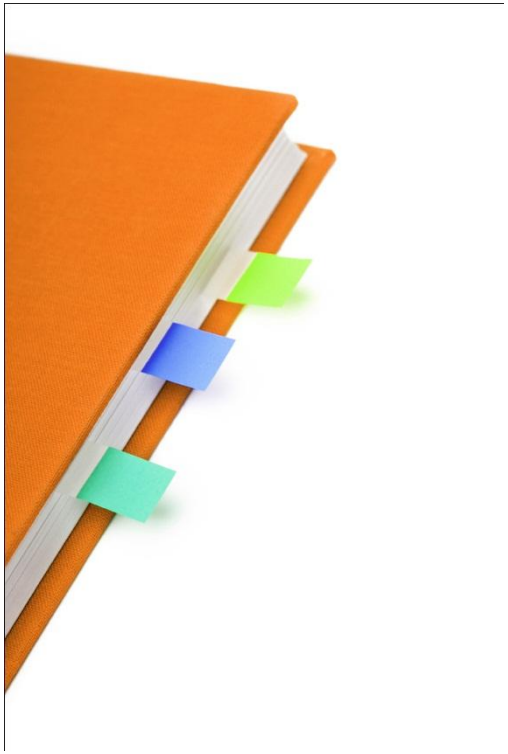
Strategy development required data

- **compiled datasets from disparate sources to determine a comprehensive look at the population**
  - what are the cost drivers?
  - who is driving the cost and for what?
  - spotlight on chronically ill members
    - identified top 5K patients accounting for 75% of total pilot population spend
    - identified opportunities to expand care program and develop additional programs

- **identified utilization outliers at the MSDRG level/established benchmarks for improved care in key areas, e.g.:**
  - OB/GYN
  - Knees and Hips
  - Bariatric

Initiatives

- IT
- Reduce
  - Drug Costs
  - Physician Variation
  - CalPERS Utilization
- Population Management



Lessons Learned

Key accomplishments

- **Strong commitment** by all organizations to work on an improved care delivery system

- **Implemented industry best practice for:**

  - ✓ discharge planning process including hospital teach back,
  - ✓ follow-up visit within 8-10 days,
  - ✓ welcome home calls
  - ✓ sharing of discharge plan with PCP

Key accomplishments (continued)

- **expanded Health Information Exchange (HIE) including:**
  - ✓ clinical results (lab, rad),
  - ✓ hospital discharge summary and patient discharge summary to IPA EMR and/or physician portal
  - ✓ IPA continuity of care (CCD) data into the hospital EMR
  - ✓ re-admission discharge plan into hospital portal
- **benchmarked acute care admissions/LOS**
  - ✓ implemented changes by service line including physician variability, hospital
    variability and clinical practices (i.e. knee replacement and hysterectomies)
  - ✓ in-house development of a high-risk patient tracking and stratification tool

Outcomes for First Year

- Grew new NetValue membership by over 2,500 members since open enrollment in Fall 2009
- Reduced readmissions by 2% - 17% reduction
- Reduced ALOS by 0.72 day for all admissions
- Reduced ER/Urgent Care Admissions by 7.6%
- Reduced total bed days by 15%

Questions/Frage?