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EMERGING HEALTHCARE TOPICS FOR DISCUSSION

**HITECH Act of 2009**
- Meaningful Use and EHR Incentive Programs

**Affordable Care Act of 2010**
- Hospital Value-Based Purchasing
- Bundled Payments
- Accountable Care Organizations
HOW IS HEALTHCARE CHANGING?

MEANINGFUL USE

MEANINGFUL USE OVERVIEW

• Eligible professionals (EPs), hospitals, and critical access hospitals (CAHs) can receive incentive payments if they can attest to the “meaningful use” of certified Electronic Health Record (EHR) technology to improve patient care.
• Two EHR incentive programs:
  o Medicare
  o Medicaid
3 COMPONENTS OF MEANINGFUL USE

1. Use of certified EHR in a meaningful manner (e.g., e-prescribing)
2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care
3. Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary

QUALIFICATION

• 50% or more of an EP’s patient encounters during EHR reporting period must occur at a location equipped with certified EHR technology
• If not 50% at one location, then 50% of patient encounters through a combination of locations
• Would base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

HOW DO ELIGIBLE PROFESSIONALS QUALIFY?

Stage 1
20 of 25 “meaningful use” objectives
• 15 core objectives
• 5 from menu of 10 set objectives
• 6 clinical quality measures
• 3 core measures
• 3 from menu of 18 set measures

Stage 2
20 of 25 “meaningful use” objectives
• 17 core objectives
• 3 from menu of 5 set objectives
• 9 of 64 clinical quality measures
• Must select from at least 3 of the 6 key health care policy domains

Stage 3
TBD
MAXIMUM EHR INCENTIVE PAYMENTS FOR ELIGIBLE PROFESSIONALS

HOW DO HOSPITALS AND CRITICAL ACCESS HOSPITALS QUALIFY?

Stage 1
- 19 of 24 "meaningful use" objectives
- 14 core objectives
- 5 from menu of 10 set objectives
- 15 clinical quality measures

Stage 2
- 20 of 22 "meaningful use" objectives
- 16 core objectives
- 2 from menu of 4 set objectives
- 16 of 29 clinical quality measures
- Must select from at least 3 of the 6 key health care policy domains

Stage 3
- TBD

HOW ARE THE MEDICARE INCENTIVE PAYMENTS CALCULATED FOR HOSPITALS AND CRITICAL ACCESS HOSPITALS?

1. Initial Amount
- $2,000,000
- Plus $200 per discharge starting with the 1,150th
- Capped at $6,370,400

2. Medicare Share

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<th>2012</th>
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3. Transition Factor

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TBD
MEANINGFUL USE CRITERIA

Details

KEY

Measures with a denominator of unique patients regardless of whether patients are maintained using EHR technology

Measures with a denominator of based on counting actions for patients whose records are maintained using certified EHR technology

Measures requiring only a yes/no attestation

MEANINGFUL USE CRITERIA

1. Computer Physician Order Entry (CPOE)
2. Electronic Prescriptions *
3. Drug to Drug Interaction & Drug to Allergy
4. Record Patient Demographics
5. Problem Lists
6. Maintain Active Medication List
7. Maintain Active Medication Allergy List
8. Record Vital Signs and Chart Changes
9. Record Smoking Status

* Not applicable to Hospitals or CAH
### Meaningful Use Criteria

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>10. Clinical Decision Support Rules</td>
<td></td>
</tr>
<tr>
<td>11. Clinical Quality Measures to CMS or states</td>
<td></td>
</tr>
<tr>
<td>12. Provide Patients with electronic copy of health information</td>
<td></td>
</tr>
<tr>
<td>13a) Provide patients with electronic copy of discharge (hospital only)</td>
<td></td>
</tr>
<tr>
<td>13b) Provide patients with clinical summaries for each office visit (EP)</td>
<td></td>
</tr>
<tr>
<td>14. Capability to exchange Key Clinical Information</td>
<td></td>
</tr>
<tr>
<td>15. Protect Electronic Health Information</td>
<td></td>
</tr>
</tbody>
</table>

### Menu Set

Select five

![Menu Set Image](image)

### Meaningful Use Menu Set

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. Drug Formulary Checks</td>
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</tr>
<tr>
<td>2. Lab Results as Structured Data</td>
<td></td>
</tr>
<tr>
<td>3. Patient Lists</td>
<td></td>
</tr>
<tr>
<td>4. Patient Education Resources</td>
<td></td>
</tr>
<tr>
<td>5. Medication Reconciliation</td>
<td></td>
</tr>
<tr>
<td>6. Care Summary Record Exchange Across Providers</td>
<td></td>
</tr>
<tr>
<td>7. Immunization</td>
<td></td>
</tr>
<tr>
<td>8. Syndromic Surveillance</td>
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</table>
MEANINGFUL USE MENU SET

<table>
<thead>
<tr>
<th>Hospital Only</th>
<th>EP Only</th>
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</thead>
<tbody>
<tr>
<td>Advance Directives</td>
<td>Patient Reminders</td>
</tr>
<tr>
<td>Lab Results to Public Health etc.</td>
<td>Patient Access to Health Info</td>
</tr>
</tbody>
</table>

* At least 1 public health objective must be selected

NEW STAGE 2 OBJECTIVES - CORE

Core Objectives:
- Provide patients the ability to view online, download, and transmit information about a hospital admission
- Automatically track medication orders using an electronic medication administration record (eMAR) (for hospitals)
- Use secure electronic messaging to communicate with patients (for professionals)

NEW STAGE 2 OBJECTIVES - MENU

1. Imaging results and information are accessible through Certified EHR Technology
2. Record patient family health history as structured data
3. Capability to identify and report cancer cases to a State cancer registry where authorized (professionals)
4. Capability to identify and report specific cases to a specialized registry, other than a cancer registry (professionals)
5. Use secure electronic messaging to communicate with patients on relevant health information (professionals)
6. Generate and transmit permissible discharge prescriptions electronically (eRx) (for hospitals)
7. Provide patients the ability to view online, download, and transmit information about a hospital admission (for hospitals)
8. Record whether a patient 65 years old or older has an advance directive (for hospitals)
RISKS OF MEANINGFUL USE

- Governance
- Group reporting of quality measures
- Patient access
- First-time order generators
- Health information exchange
- Lab results
- Demographics increase
- ICD-10 impact
- Tight timetables
- All patients in denominator

MEANINGFUL USE
WHAT TO AUDIT

- Risk assessment of Meaningful Use
- Complex reporting challenges
- EHR Reporting limitations
- Governance
- Attestation
- Evidence
  - Eligible Provider
  - Denominator/Numerator calculations

HOSPITAL VALUE-BASED PURCHASING
HOSPITAL VALUE-BASED PURCHASING
OVERVIEW

- CMS initiative that rewards acute-care hospitals with incentive payments based on quality of care provided to Medicare patients
- Payments will begin January 2013 for care after October 1, 2012
  - Based on performance period July 1, 2011 to March 31, 2012
- In future years, the performance period will be a full year
- Performance based on data collected through the Hospital Inpatient Quality Reporting (IQR) Program

HOSPITAL VALUE-BASED PURCHASING
ELIGIBILITY

- FFY 2013
  - Must report on at least four measures during the performance period with a minimum of 10 cases per measure for the Clinical Process of Care score
  - Must report the results of at least 100 HCAHPS surveys during the performance period for the Patient Experience of Care score
- FFY 2014
  - In addition to FFY 2013 eligibility requirements, must report on at least two measures during the performance period with a minimum of 10 cases per measure for the Outcome Mortality score

HOSPITAL VALUE-BASED PURCHASING
SOURCE OF FUNDING

Participating hospitals will have their base operating DRG payments reduced by the following in order to fund the incentive payments:

- FFY 2013: 1.0%
- FFY 2014: 1.25%
- FFY 2015: 1.5%
- FFY 2016: 1.75%
- FFY 2017+: 2.0%
HOSPITAL VALUE-BASED PURCHASING SCORING

- **Achievement Score**
  - Based on where the performance for the measure falls relative to the achievement threshold and benchmark

- **Improvement Score**
  - Based on how much the performance for the measure during the performance period improved compared to the baseline period

- **Consistency Score**
  - Based on the lowest of the eight HCAHPS dimension scores

HOSPITAL VALUE-BASED PURCHASING FFY 2013 SCORE WEIGHTING

- CMS will assess how much each hospital’s performance during the performance period changes from baseline period performance.
- CMS will award achievement points if performance exceeds 50th percentile of all hospitals in baseline period.

HOSPITAL VALUE-BASED PURCHASING FFY 2014 SCORE WEIGHTING

- CMS will assess how much each hospital’s performance during the performance period changes from baseline period performance.
- CMS will award achievement points if performance exceeds 50th percentile of all hospitals in baseline period.
HOSPITAL VALUE-BASED PURCHASING INCENTIVE PAYMENT

![Graph showing Hospital Value-Based Purchasing Incentive Payment](image)

Source: Centers for Medicare & Medicaid Services

HOSPITAL VALUE-BASED PURCHASING BONUSES AND PENALTIES DISCLOSED

- In December 2012, CMS disclosed which hospitals will receive bonuses and penalties from the nearly $1 billion pool
  - 1,557 hospitals will receive bonuses while 1,427 hospitals will receive penalties
  - Biggest bonus - Treasure Valley Hospital in Boise, Idaho (0.83% increase)
  - Worst Case - Auburn Community Hospital in upstate New York (losing 0.9%)
  - In California, 44% are getting bonuses and 56% are getting penalties for a negative change of -0.03%


HOSPITAL VALUE-BASED PURCHASING RISKS AND CONSIDERATIONS

- Validity and reliability of measures
  - Volume of measures
  - Non-standardization of measures
  - Implementation of HIT and EHRs can help facilitate the collection of quality data
- Unintended consequences of providers shifting resources to quality measures that offer rewards and neglect quality measures that offer no rewards
WHAT SHOULD INTERNAL AUDIT FOCUS ON?

- Data that is captured, monitored, and mined
- IT change management
- Contracting
- Clinical protocols
- Physician alignment compensation programs
- Reimbursement model changes

BUNLED PAYMENTS

IT’S NOT A NEW CONCEPT

1993
- Medicare's Cataract Surgery Alternate Payment Demo
- Geisinger Health System's ProvenCare
- PROMETHEUS Payment, Inc.

2009
- Fairview Health Services
- Blue Cross Blue Shield of Mass.
- Medicare's Acute Care Episode Demo

1991
- Medicare's Participating Heart Bypass Center Demo

1987
- Dr. Johnson and Ingham Medical Center
BUNDLED PAYMENTS EXAMPLE
WHAT’S INCLUDED AND HOW IS IT PRICED?

High Cost Episode of Care

Low Cost Episode of Care

Agreed Upon Price per Episode of Care
Facility + Professional = $31,200

Hospitalization PAC SNF Readmissions
Pre-op Visit Post-op Visit

Pre-op Visit Post-op Visit

Pre-op Visit Post-op Visit

Pre-op Visit Post-op Visit

PREVIOUS PAGE CONTINUED

METHODOLOGY

MEDICARE BUNDLED PAYMENTS FOR
CARE IMPROVEMENT INITIATIVE

Model 1
• Retrospective
• Acute Care Hospital Stay Only
• All MS-DRGs
• Minimum discount of 0% in the first 6 months to 2% in Year 2

Model 2
• Retrospective
• Acute Care Hospital Stay + Post-Acute + Readmissions
• 48 bundle definitions to choose from
• Minimum discount 3% for 30 or 60 days and 2% for 90 days

Model 3
• Retrospective
• Post-Acute Only
• 48 bundle definitions to choose from
• Minimum discount of 3% regardless of days (30, 60, or 90)

Model 4
• Prospective
• Acute Care Hospital Stay + Readmissions
• 48 bundle definitions to choose from
• Minimum discount of 3.5% for ACE Demo MS-DRGs and 3% for all others

EPISODE CONVERGENCE FOR MODELS 2-4

Episode Name

1 Acute myocardial infarction
2 Major bowel amputation
3 Atherosclerosis
4 Automatic implantable cardiac defibrillator generator or lead
5 Back and neck except spinal fusion
6 Cardiac arrhythmia
7 Cardiac defibrillator
8 Cardiac valve
9 Cellulitis
10 Cervical spinal fusion
11 Chest pain
12 Chronic obstructive pulmonary disease, bronchitis/asthma
13 Combined anterior posterior spinal fusion
14 Complex non-Cervical spinal fusion
15 Congestive heart failure
16 Coronary artery bypass graft surgery
17 Diabetes
18 Double joint replacement of the lower extremity
19 Esophagitis, gastroenteritis and other digestive disorders
20 Fractures femur and hip/pelvis
21 Gastrointestinal hemorrhage
22 Gastrointestinal obstruction
23 Hip and femur procedures except major joint
24 Lower extremity and humerus procedure except hip, foot, femur
25 Major bowel amputation
26 Major cardiovascular procedure
27 Major joint replacement of the lower extremity
28 Major joint upper extremity
29 Medical non-infectious orthopedic procedures
30 Medical peripheral vascular disorders
31 Nutritional and metabolic disorders
32 Other knee procedures
33 Other vascular surgery
34 Pacemaker
35 Pacemaker Device replacement or revision
36 Medical non-infectious orthopedic procedures
37 Percutaneous coronary intervention
38 Red blood cell disorders
39 Removal of orthopedic devices
40 Renal failure
41 Revision of the hip or knee
42 Sepsis
43 Simple pneumonia and respiratory infections
44 Spinal fusion (non-Cervical)
45 Stroke
46 Syncope and collapse
47 Transient ischemia
48 Urinary tract infection
BUNDLED PAYMENTS RISKS

• Selecting episode definition, episode length, and payment discount
• Administering claims for prospective models
• Determination of gains or losses
• Waivers and gainsharing agreements
• Care redesign plans
• Beneficiary inducement
• Business and financial arrangements
• Physician engagement plans

BUNDLED PAYMENTS – WHAT SHOULD INTERNAL AUDIT MONITOR?

• Contracts
• Definitions of data to reporting of data
• Reimbursement
• Financial modeling and budgets
• Tracking of patient’s pathway through episode of care
• How costs are separated between typical and avoidable

ACCOUNTABLE CARE ORGANIZATIONS
ACCOUNTABLE CARE ORGANIZATIONS

WHAT ARE THEY?

- Groups of doctors, hospitals, and other health care providers who come together contractually to:
  - Deliver high quality care
  - Coordinate care across a spectrum of care settings
  - Serve a specific patient population
- Rewarded for keeping health care costs lower while meeting performance standards on quality of care

ACCOUNTABLE CARE ORGANIZATIONS

COMMON PAYMENT ARRANGEMENTS

Fully Capitated
- Providers contract to provide defined health services to a specific patient population for a predetermined capitation fee

Risk Pools
- Both favorable and unfavorable financial results are shared among providers with final settlements typically occurring at the end of each contract term

Shared Savings
- Parties agree to share risk through risk pools designated to pay incentives to providers who meet contractual metrics such as cost control

IMPORTANCE OF INFORMATION

- Enabling effective care coordination across the continuum to develop a community of providers that actively collaborate in treating patients
- Connecting system participants through real-time interoperable information exchange
- Linking EHRs to support population health and payment systems
- Analyzing and reporting based on quality measurement requirements
- Providing patients with the right information to accept responsibility for ongoing care
MEDICARE SHARED SAVINGS PROGRAM (MSSP)

- A separate legal entity to coordinate care for Medicare fee-for-service beneficiaries
- Three-year agreements with CMS
- Entity must have at least 5,000 attributed beneficiaries
- Continue to receive traditional Medicare fee-for-service payments with two shared savings models to choose from

MSSP MODELS

<table>
<thead>
<tr>
<th>Track 1 - Less Risk, Lower Reward</th>
<th>Track 2 - More Risk, Higher Reward</th>
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<tbody>
<tr>
<td>• Share in savings only with no downside risk</td>
<td>• Share in both savings and losses</td>
</tr>
<tr>
<td>• Eligible to receive up to 50% of savings from the reduction in cost compared to benchmark</td>
<td>• Eligible to receive up to 60% of savings from the reduction in cost compared to benchmark but liable for up to 40% of the loss</td>
</tr>
<tr>
<td>• Payments capped at 10% of benchmark</td>
<td>• Payments capped at 15% of benchmark. Losses capped at 5%, 7.5%, and 10% for years 1, 2, and 3 respectively</td>
</tr>
<tr>
<td>• Minimum savings rate is a sliding scale based on the number of assigned beneficiaries</td>
<td>• Minimum savings rate is a flat 2%</td>
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<tr>
<td>• Subject to reporting and performance on 33 quality measures</td>
<td>• Subject to reporting and performance on 33 quality measures</td>
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DATA MANAGEMENT TOOLS

- Identity Management
- Patient Registries
- Predictive Modeling
- EHR Integration
- Reminder Systems
- Episode of care analytics
MSSP RISKS

- Management of data - Data sharing capabilities for internal quality and cost reporting
- Accurate data submission
- Conflict of Interest within participants
- Hierarchical Condition Category (HCC) Coding
- Appropriate accounting treatment for recognizing revenue under ACO arrangements
- Obtaining timely and accurate data to estimate the shared savings
- Mandatory Compliance Program

WHAT SHOULD INTERNAL AUDIT MONITOR?

- Revisit the risks and control testing
  - Tone at Top
  - Inventory all data systems and sources that form the basis for clinical data and document process flow
  - Data definitions
    - Confirm data definitions are consistent with reporting standards
    - Verify that data definitions cannot be manipulated by users
  - Consistency
  - Accuracy
  - Completeness
  - Recalculation and testing of risk areas

THANK YOU!