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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

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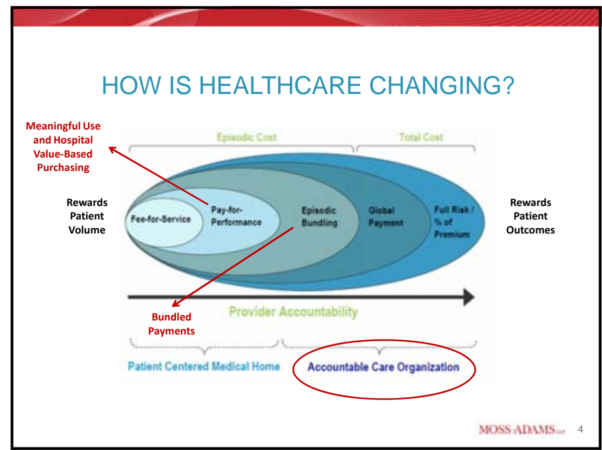

MEANINGFUL USE OVERVIEW

- 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:
  - Medicare
  - Medicaid

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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 38 set measures

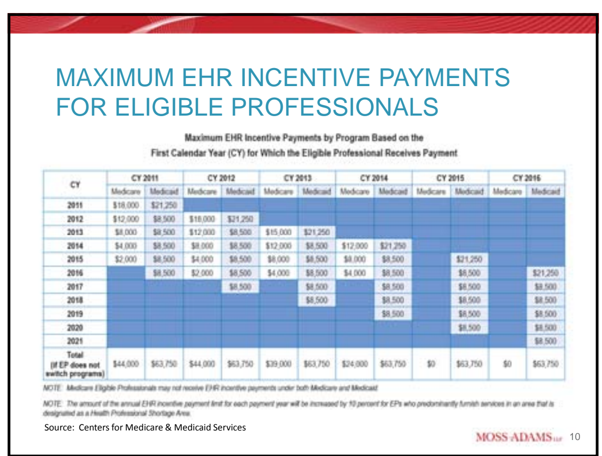
Stage 2

20 of 25 "meaningful use" objectives
- **17** core objectives
- **3** from menu of 5 set objectives

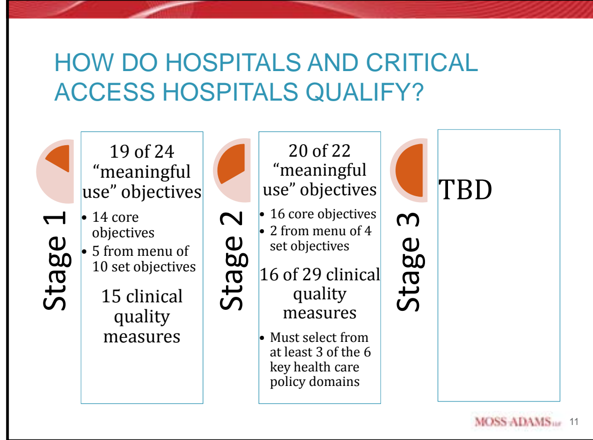
9 of 64 clinical quality measures
- Must select from at least 3 of the 6 key health care policy domains

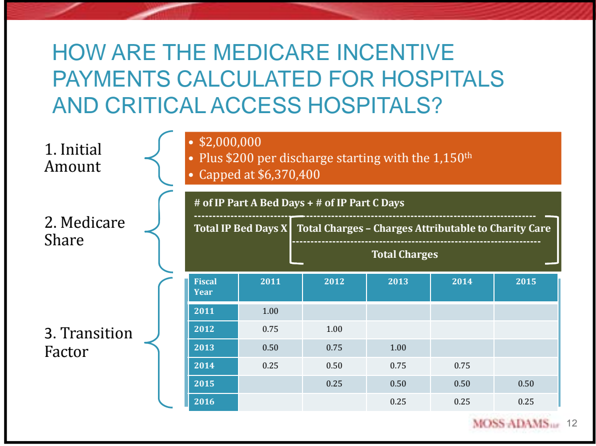
Stage 3

TBD

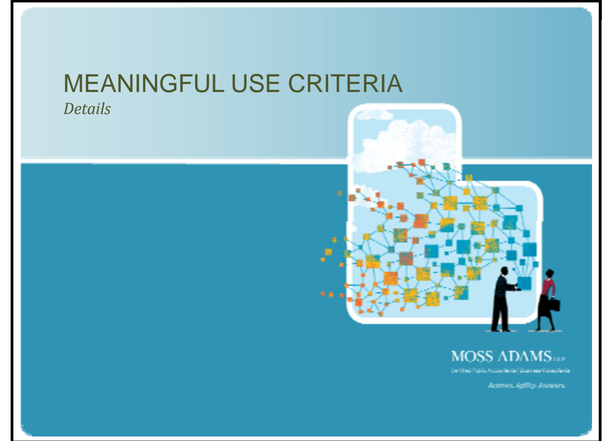


CY	CY 2011		CY 2012		CY 2013		CY 2014		CY 2015		CY 2016	
	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid
2011	$18,000	$21,250										
2012	$12,000	$8,500	$18,000	$21,250								
2013	$8,000	$8,500	$12,000	$8,500	$15,000	$21,250						
2014	$4,000	$8,500	$8,000	$8,500	$12,000	$8,500	$12,000	$21,250				
2015	$2,000	$8,500	$4,000	$8,500	$8,000	$8,500	$8,000	$8,500		$21,250		
2016		$8,500	$2,000	$8,500	$4,000	$8,500	$4,000	$8,500		$8,500		$21,250
2017				$8,500		$8,500		$8,500		$8,500		$8,500
2018						$8,500		$8,500		$8,500		$8,500
2019								$8,500		$8,500		$8,500
2020										$8,500		$8,500
2021												$8,500
Total (If EP does not switch programs)	$44,000	$63,750	$44,000	$63,750	$39,000	$63,750	$24,000	$63,750	$0	$63,750	$0	$63,750





Fiscal Year	2011	2012	2013	2014	2015
2011	1.00				
2012	0.75	1.00			
2013	0.50	0.75	1.00		
2014	0.25	0.50	0.75	0.75	
2015		0.25	0.50	0.50	0.50
2016			0.25	0.25	0.25



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

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MEANINGFUL USE CRITERIA

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

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MEANINGFUL USE CRITERIA

Criterion	
10. Clinical Decision Support Rules	✚
11. Clinical Quality Measures to CMS or states	
12. Provide Patients with electronic copy of health information	▲ ☆
13a) Provide patients with electronic copy of discharge (hospital only)	▲
13b) Provide patients with clinical summaries for each office visit (EP)	
14. Capability to exchange Key Clinical Information	✚
15. Protect Electronic Health Information	✚

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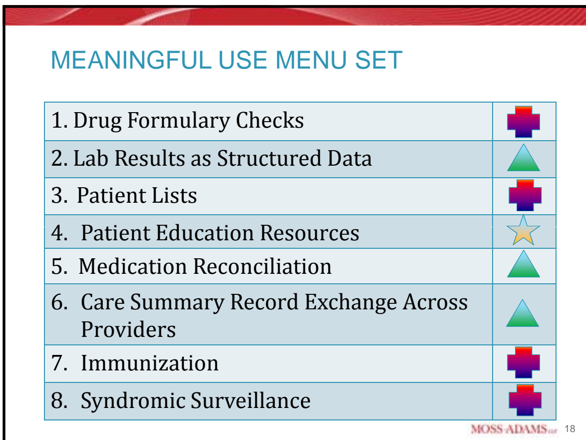

MEANINGFUL USE MENU SET

Measure	
1. Drug Formulary Checks	✚
2. Lab Results as Structured Data	▲
3. Patient Lists	✚
4. Patient Education Resources	☆
5. Medication Reconciliation	▲
6. Care Summary Record Exchange Across Providers	▲
7. Immunization	✚
8. Syndromic Surveillance	✚

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MEANINGFUL USE MENU SET

Hospital Only	
Advance Directives	
Lab Results to Public Health etc.	
EP Only	
Patient Reminders	
Patient Access to Health Info	

* At least 1 public health objective must be selected

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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)

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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)

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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

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MEANINGFUL USE
WHAT TO AUDIT

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

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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

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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

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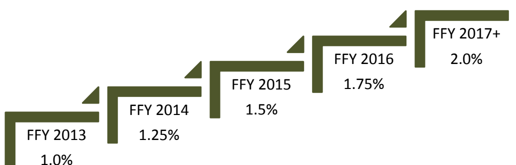
HOSPITAL VALUE-BASED PURCHASING SOURCE OF FUNDING

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



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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

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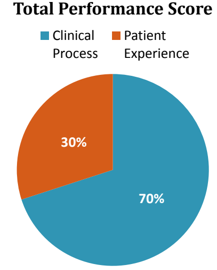
HOSPITAL VALUE-BASED PURCHASING FFY 2013 SCORE WEIGHTING

Total Performance Score



- 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.

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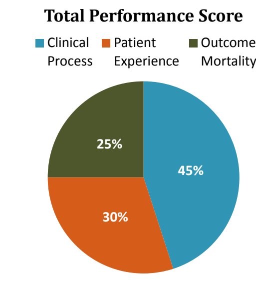
HOSPITAL VALUE-BASED PURCHASING FFY 2014 SCORE WEIGHTING

Total Performance Score



- 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.

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HOSPITAL VALUE-BASED PURCHASING INCENTIVE PAYMENT

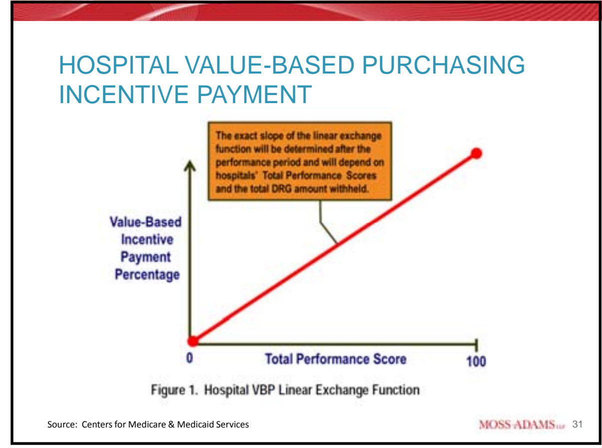

Figure 1. Hospital VBP Linear Exchange Function

Source: Centers for Medicare & Medicaid Services

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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%

Source: Kaiser Health News, "Medicare Discloses Hospitals' Bonuses, Penalties Based on Quality", December 20, 2012

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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

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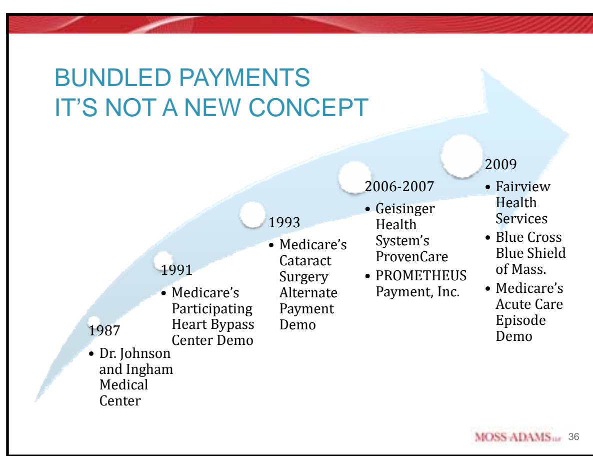
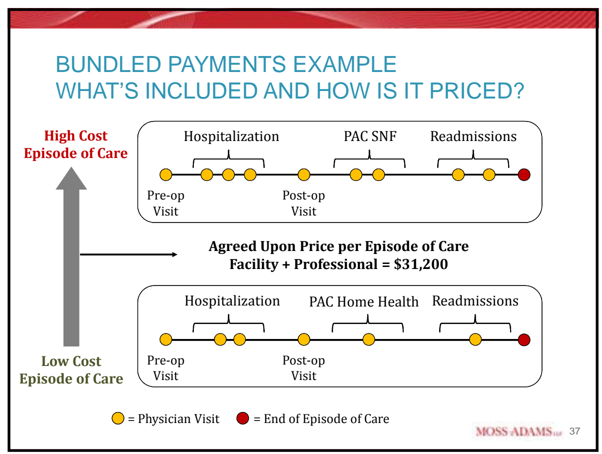
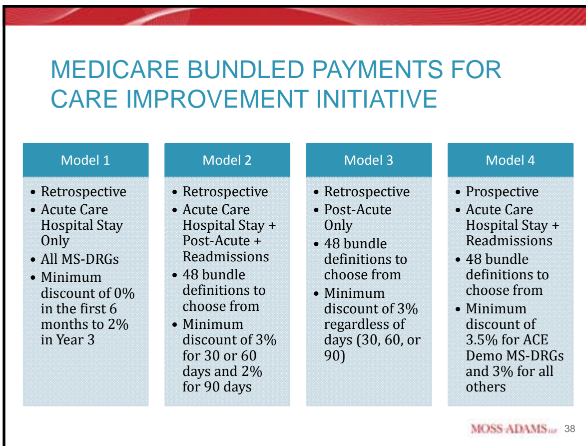
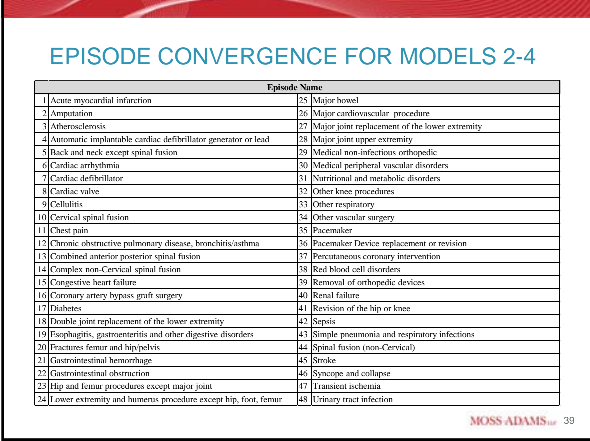
WHAT SHOULD INTERNAL AUDIT FOCUS ON?

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








EPISODE CONVERGENCE FOR MODELS 2-4

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

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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

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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

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ACCOUNTABLE CARE ORGANIZATIONS

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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

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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

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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

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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

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MSSP MODELS

Track 1 – Less Risk, Lower Reward	Track 2 – More Risk, Higher Reward
• Share in savings only with no downside risk • Eligible to receive up to 50% of savings from the reduction in cost compared to benchmark • Payments capped at 10% of benchmark • Minimum savings rate is a sliding scale based on the number of assigned beneficiaries • Subject to reporting and performance on 33 quality measures	• Share in both savings and losses • 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 • Payments capped at 15% of benchmark. Losses capped at 5%, 7.5%, and 10% for years 1, 2, and 3 respectively • Minimum savings rate is a flat 2% • Subject to reporting and performance on 33 quality measures

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DATA MANAGEMENT TOOLS

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

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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