Emerging Healthcare Issues:
How Will They Impact Hospital Reimbursement?  Part 1

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Lori Laubach, Partner
Sharon Hartzel, Director
Moss Adams LLP
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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
HOW IS HEALTHCARE CHANGING?

Meaningful Use and Hospital Value-Based Purchasing

Rewards Patient Volume

Episodic Cost

Total Cost

Provider Accountability

Bundled Payments

Fee-for-Service

Pay-for-Performance

Episodic Bundling

Global Payment

Full Risk / % of Premium

Rewards Patient Outcomes

Patient Centered Medical Home

Accountable Care Organization
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:
  - Medicare
  - 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
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
# Maximum EHR Incentive Payments for Eligible Professionals

Maximum EHR Incentive Payments by Program Based on the First Calendar Year (CY) for Which the Eligible Professional Receives Payment

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<td>Total (if EP does not switch programs)</td>
<td>$44,000</td>
<td>$63,750</td>
<td>$44,000</td>
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**NOTE:** Medicare Eligible Professionals may not receive EHR incentive payments under both Medicare and Medicaid.

**NOTE:** The amount of the annual EHR incentive payment limit for each payment year will be increased by 10 percent for EPs who predominantly furnish services in an area that is designated as a Health Professional Shortage Area.

Source: Centers for Medicare & Medicaid Services
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

3. Transition Factor

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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

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<th>Criterion</th>
<th>Status</th>
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<tr>
<td>1</td>
<td>Computer Physician Order Entry (CPOE)</td>
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<td>2</td>
<td>Electronic Prescriptions *</td>
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<td>3</td>
<td>Drug to Drug Interaction &amp; Drug to Allergy</td>
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<tr>
<td>4</td>
<td>Record Patient Demographics</td>
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<tr>
<td>5</td>
<td>Problem Lists</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Maintain Active Medication List</td>
<td></td>
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<tr>
<td>7</td>
<td>Maintain Active Medication Allergy List</td>
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<tr>
<td>8</td>
<td>Record Vital Signs and Chart Changes</td>
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<tr>
<td>9</td>
<td>Record Smoking Status</td>
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* Not applicable to Hospitals or CAH
<table>
<thead>
<tr>
<th>MEANINGFUL USE CRITERIA</th>
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<tr>
<td>10. Clinical Decision Support Rules</td>
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<tr>
<td>11. Clinical Quality Measures to CMS or states</td>
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<tr>
<td>12. Provide Patients with electronic copy of health information</td>
</tr>
<tr>
<td>13a) Provide patients with electronic copy of discharge (hospital only)</td>
</tr>
<tr>
<td>13b) Provide patients with clinical summaries for each office visit (EP)</td>
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<tr>
<td>14. Capability to exchange Key Clinical Information</td>
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<td>15. Protect Electronic Health Information</td>
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MENU SET
Select five
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<td>1.</td>
<td>Drug Formulary Checks</td>
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<td>2.</td>
<td>Lab Results as Structured Data</td>
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<td>3.</td>
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<td>4.</td>
<td>Patient Education Resources</td>
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<td>5.</td>
<td>Medication Reconciliation</td>
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<td>6.</td>
<td>Care Summary Record Exchange Across Providers</td>
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<td>7.</td>
<td>Immunization</td>
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<td>8.</td>
<td>Syndromic Surveillance</td>
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<tr>
<td>Advance Directives</td>
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<td>Lab Results to Public Health etc.</td>
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<tr>
<td>Patient Reminders</td>
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<td>Patient Access to Health Info</td>
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* At least 1 public health objective must be selected
CMS MU AUDITS

• CMS has engaged Figliozzi and Company to perform audits
• If selected, you will receive a letter from Figliozzi
• Per CMS
  “It is the provider’s responsibility to maintain documentation that fully supports the meaningful use and clinical quality data submitted during attestation.”¹
• numerous pre-payment edit checks to detect inaccuracies in eligibility, reporting, and payment

RISKS OF MEANINGFUL USE

- Numerators and Denominators
- Group reporting of quality measures
- Enrollment information
- Patient access
- First-time order generators
- Security risk analysis
- Lab results
- Demographics increase
- ICD-10 impact
- Tight timetables
MEANINGFUL USE
WHAT TO AUDIT

• Risk assessment of Meaningful Use
• Complex reporting challenges
• EHR Reporting limitations
• Attestation
• Evidence
  o Eligible Provider/hospital
  o Denominator/Numerator calculations
  o Dual eligibility
HOSPITAL VALUE-BASED PURCHASING

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

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
  o 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
  o 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
  o Must report the results of at least 100 HCAHPS surveys during the performance period for the **Patient Experience of Care** score

• FFY 2014
  o 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

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 performance.
HOSPITAL VALUE-BASED PURCHASING
FFY 2014 SCORE WEIGHTING

**Total Performance Score**

- Clinical Process: 45%
- Patient Experience: 30%
- Outcome Mortality: 25%

- 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 performance.
HOSPITAL VALUE-BASED PURCHASING INCENTIVE PAYMENT

Figure 1. Hospital VBP Linear Exchange Function

The exact slope of the linear exchange function will be determined after the performance period and will depend on hospitals’ Total Performance Scores and the total DRG amount withheld.

Source: Centers for Medicare & Medicaid Services
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
  o Volume of measures
  o Non-standardization of measures
  o 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
THANK YOU!

lori.laubach@mossadams.com
sharon.hartzel@mossadams.com