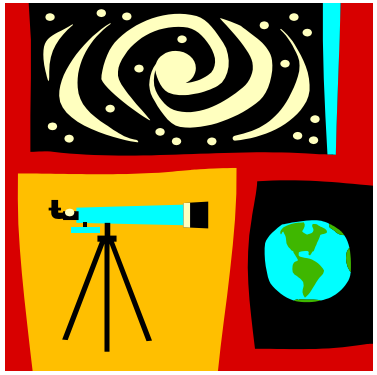
LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

Health Reform and the Patient Protection and Affordable Care Act: Effects on our Institutions and Members

Marcia Mayfield, Labor Management Project

NOVEMBER 14, 2013



THIS SESSION'S AGENDA

1. Health Care Reform
2. Trends Impacting the Workforce
3. Payment Reform and the Patient Protection & Affordable Care Act
4. Value-Based Purchasing
5. Readmission Penalties
6. Hospital-Acquired Conditions Program
7. What's at Risk?
8. PPACA and Nursing Homes

Health Care Reform

- PPACA is part of a larger reform effort that began before 2010
- Reform is aimed at expanding access, increasing quality, and decreasing cost

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

Health Care Reform Changes

- Shift in focus for the health care delivery system to primary and preventive care
- Emphasis on effective management of chronic diseases
- Emerging models of care, such as the patient-centered medical home, health homes, accountable care organizations
- Payment reform, e.g., incentives for keeping people healthy, penalties for inappropriate hospital readmissions, incentives for quality

Converging Trends Are Driving the shift to Primary care

- Current system:
  - Reactive, fragmented, episodic, disease-oriented, fee-for-service driven
  - Rising epidemic of chronic illness
  - Inability to control cost without prevention, primary care
  - Soaring health care costs combined with budgetary crises, especially at the State level

Major Developments and Trends Impacting the Health Workforce

- Demand rising as the US population is growing and aging
- Health care reform will add insurance coverage for millions and improve coverage for millions more
- Unsustainable cost increases
- Concerns about health workforce shortages
- Concern with inefficiencies and potential overuse
- Increasing interest in identifying ways to improve efficiency and health outcomes

Major Developments and Trends Impacting the Health Workforce (Continued)

- Delivery system reforms and growing size of health care organizations
- Increasing use of inter-professional teams
- Disruptive innovations (e.g. increased use of non-physician clinicians; retail clinics)
- Technology (EMR, Tele-health)
- Increased attention on outcomes and metrics
- Patient/consumer empowerment

CMS Health Care Innovation Awards

- Most approved projects include plans to use workers in new ways; common themes include:
  - Care coordinators and better management of patients
  - Use of inter-professional teams
  - Use of patient navigators
  - Use of community health workers
  - Use of advanced aides, assistants
  - Improved care transitions and in-home services
  - Greater use of telemedicine and Health Information Technology (HIT)

Small Group Discussion

- What are the implications of these trends for our members and institutions?

Report Out

Overall Workforce Implications

- Doing more with less
- Training and education
- Teams and collaborative practice
- Making better use of the workers we have
- New categories/variations on support personnel
- Reassessment of scope of work
- Increased use of technology
- Increased efforts to align federal funds with health workforce needs

Payment Reform

- Elimination of Payments for
  - Select re-admissions
  - Healthcare-Acquired Conditions/Serious Adverse Events
  - Disproportionate share hospitals (DSH)
- Value Based Purchasing (Pay-for-Performance)
  - Hospital Consumer Assessment of Healthcare Providers & Survey (HCAHPS)
  - Core Measures
  - Outcomes
- Nursing Homes
  - Shift to home and community based settings

Patient Protection & Affordable Care Act

1 Better health.

2 Better care.

3 Lower costs.

- Health insurance coverage reforms
- Hospital-based Pay-for-Performance
- Testing new of payment and service delivery models (medical homes, accountable care organizations, bundled payments)

P4P Programs Beginning in FY 2009

- **Hospital Acquired Conditions**: CMS discontinued IPPS payments for 10 preventable HACs
- **Hospital Inpatient Quality Reporting Program**: Requirement to report outcome, process of care, structure, and patient experience data (2% penalty for failure to report)

Hospital Payment Elements of PPACA

Value Based Purchasing (VBP) Program

Hospital Readmissions Reduction Program

Hospital Acquired Condition (HAC) Reduction Program

1. VALUE-BASED PURCHASING PROGRAM

- Links hospitals' Medicare payment to quality performance
- Quality measures include:
  - ❑ Clinical Process of Care (FY2013)
  - ❑ Patient Experience of Care (FY2013)
  - ❑ Patient Outcomes (FY2014)
  - ❑ Efficiency (FY2015)

How Does VBP Work?

- Base operating DRG Payments are reduced for all IPPS hospitals, creating **a pool of funds for re-distribution**
- The percent reduction increases from 1% in FY 2012 to 2% in FY 2017
- Hospitals can gain or lose, based on their performance on established measures

VBP Domains and Weights

VBP Fiscal Year	2013	2014	2015
Percent Contribution of Base DRG Payments	1.00%	1.25%	1.50%
Process of Care	70%	40%	20%
Patient Experience (HCAHPS)	30%	30%	30%
Outcome	--	25%	30%
Efficiency (Medicare spending per Beneficiary)	--	--	20%

CMS Shift for Quality Measurement:

Clinical Process Measures *(not risk-adjusted)* → Outcomes and Efficiency Measures *(risk-adjusted)*

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

FY2013 VBP: How Did We Do?

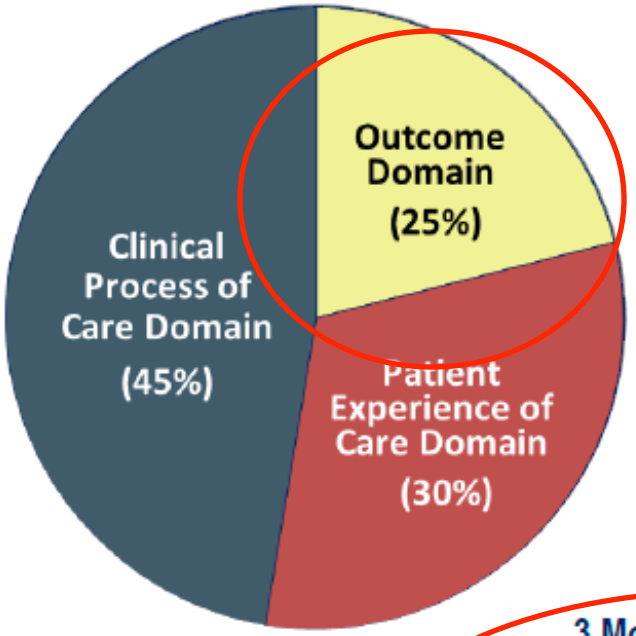
State/ Area	Average 2013 VBP Penalties	Percent of Hospitals Receiving a Penalty	Average 2013 VBP Bonuses	Percent of Hospitals Receiving a Bonus	Overall Average
Florida	-0.20%	43%	0.23%	57%	**0.04%**
Mass.	-0.19%	46%	0.19%	54%	**0.01%**
New Jersey	-0.18%	50%	0.18%	50%	**-0.01%**
New York	-0.26%	74%	0.17%	26%	**-0.14%**
District of Columbia	-0.33%	100%	N/A	0%	**-0.33%**

FY2014 Finalized domains and measures/ dimensions

13 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received within 90 Minutes of Hospital Arrival
3. HF-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. ★ **SCIP–Inf–9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2.**
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
13. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Domain Weights



8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness and Quietness
7. Discharge Information
8. Overall Hospital Rating

3 Mortality Measures ★

1. MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN Pneumonia (PN) 30-day mortality rate

★ Represents a new measure for the FY 2014 Program not in the FY 2013 Program.

FY 2015 Outcome Measures (30% of VBP Score)

Outcome Measure
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
Heart Failure (HF) 30-Day Mortality Rate
Pneumonia (PN) 30-Day Mortality Rate
AHRQ Patient Safety Indicator Composite
Central Line-Associated Bloodstream Infection (CLABSI)

NEW!

NEW!

AHRQ Patient Safety Indicator Composite

PSI 03 – Pressure Ulcer Rate
PSI 06 – Iatrogenic Pneumothorax Rate
PSI 07 – Central Venous Catheter-Related Bloodstream Infection Rate
PSI 08 – Postoperative Hip Fracture Rate
PSI 12 – Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate
PSI 13 – Postoperative Sepsis Rate
PSI 14 – Postoperative Wound Dehiscence Rate
PSI 15 – Accidental Puncture or Laceration Rate

FY 2015 Efficiency Measure (20% of VBP Score)

- Medicare Spending per Beneficiary

2. Readmission Penalties Began in FY 2013

- Hospitals with higher-than-average 30-day risk-adjusted readmission rates for **heart failure, acute myocardial infarction, and pneumonia** receive reduced Medicare payments, capped at a maximum of 1% of inpatient payments in FY 2013

- Penalties increase to a maximum of 2% of inpatient payments in FY 2014 and 3% from FY 2015 onwards.

- FY 2015 will add COPD, and elective knee and hip replacement

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

2013 and 2014 Readmissions Penalties

State/ Area	Average Readmissions Penalties 2013	Average Readmissions Penalties 2014
Florida	0.31%	0.29%
Massachusetts	0.44%	0.40%
New Jersey	0.67%	0.61%
New York	0.51%	0.44%
District of Columbia	0.50%	0.34%

3. HAC Reduction Program

- In FY 2015, hospitals with HAC incidence rates in top quartile (e.g. worst performers) will receive a 1% reduction in payment
- Includes Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments
- This HAC program is in addition to the HAC Non-Payment Program that began in 2009

HAC Program Domains and Measures

Domain 1
(AHRQ Measure)

Weighted 35%

AHRQ PSI-90 Composite

This measure consists of:

PSI-3: pressure Ulcer
PSI-6: Iatrogenic pneumothorax
PSI-7: central venous catheter-related blood stream infection rate.
PSI-8: hip fracture rate
PSI-12: postoperative PE/DVT rate
PSI-13: sepsis rate
PSI-14: wound dehiscence rate
PSI-15: accidental puncture

Domain 2
(CDC Measures)

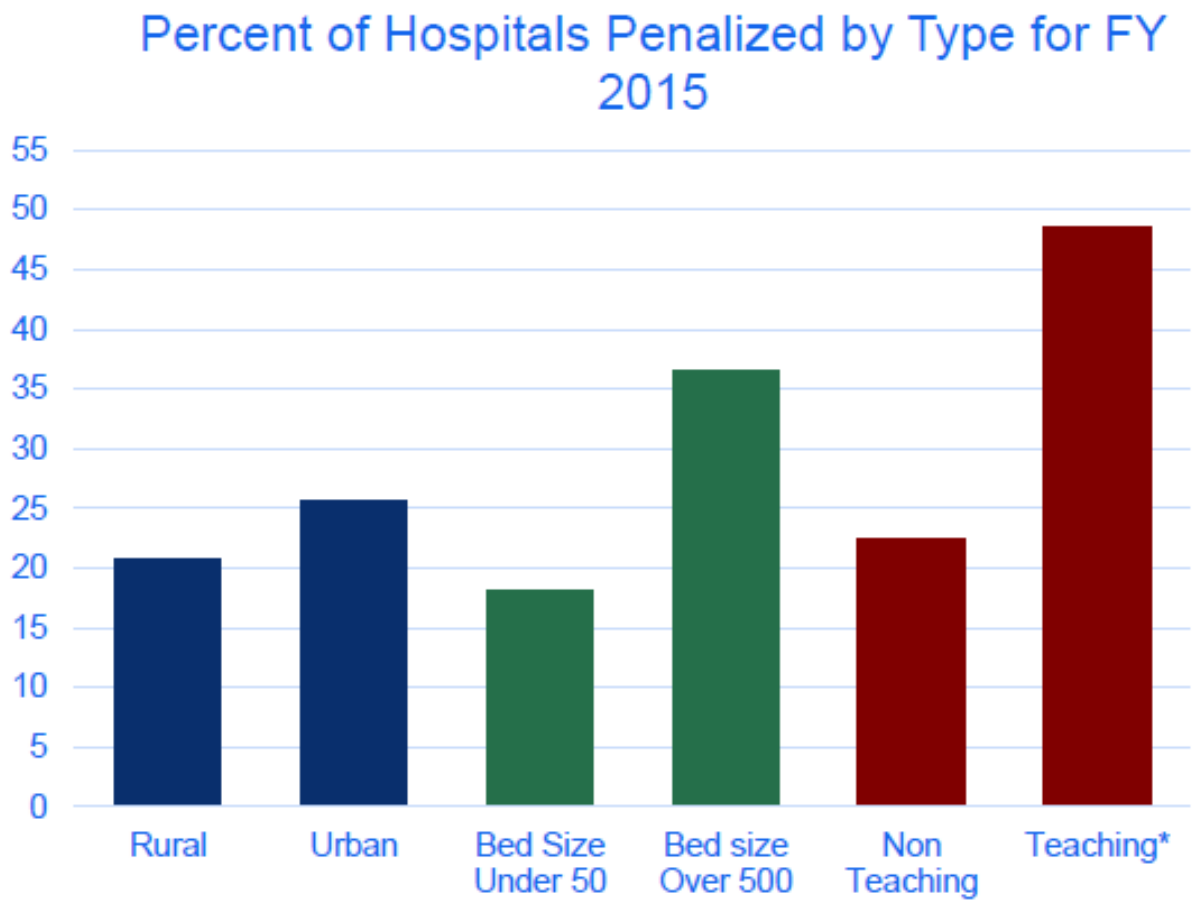
Weighted 65%

2015 (2 measures):
CAUTI
CLABSI

2016 (1 additional measure):
Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)

2017 (2 additional measures):
MRSA
C Diff

Which Hospitals Will be Affected under the Hospital Acquired Condition Reduction program?



Source: FY 2014 IPPS Final Rule, Display Copy Pp 2156-2157
*The CMS analysis identifies 276 teaching hospitals, which is low. CMS did not provide a rationale for how the 276 were selected.

Up to 8% of CMS Payment "at risk" by FY 2017

	FY14	FY15	FY16	FY17
Hospital Inpatient Quality Reporting	2% reduction for failure to report	2% reduction for failure to report	2% reduction for failure to report	2% reduction for failure to report
Hospital Acquired Conditions	No additional payment for 10 HACs	1% reduction in payment if HAC incidence is in top Quartile	1% reduction in payment if HAC incidence is in top Quartile	1% reduction in payment if HAC incidence is in top Quartile
Hospital Readmissions	2% reduction, AMI, HF, PN	3% reduction , AMI, HF, PN, COPD	3% reduction , AMI, HF, PN, COPD	3% reduction , AMI, HF, PN, COPD
Value Based Purchasing	Up to 1.25% reduction or addition	Up to 1.5% reduction or addition	Up to 1.75% reduction or addition	Up to 2% reduction or addition
TOTAL CMS Payment At Risk	**5.25%**	**7.5%**	**7.75%**	**8%**

Not to Mention EMR Meaningful Use

- Medicare eligible hospitals (those paid under IPPS) that are not meaningful users will be subject to a payment adjustment beginning on October 1, 2014. This includes hospitals that are eligible but that decide not to participate.

And What About… Maryland ?

- Maryland receives a federal waiver that exempts its hospitals from national Medicare and state Medicaid fee schedules.
- Since 1977, the State government has set specific payment rates used by <u>all payers</u> for inpatient and outpatient services

And What About… Maryland ?

- Maryland's Quality-Based Reimbursement Program adjusts individual hospital payment rates annually based on performance
  - Adherence to evidence-based care processes for HF, PN, heart attack, and surgical care
  - Patient care experience (HCAHPS)
  - Overall risk-adjusted mortality rates
- HAC Program limits payments to hospitals for treating 49 potentially preventable complications

PPACA and Nursing Homes

- To expand quality of care-related requirements for nursing homes that participate in Medicare & Medicaid
- To improve federal oversight and enforcement

Improving Nursing Home Transparency and Accountability

- Nursing homes disclose information on ownership and control
- CMS to establish national system to collect and report payroll data; re-design cost reports
- CMS to add new information to Nursing Home Compare website, including staffing, health inspections, penalties, consumer complaints
- CMS to develop standard complaint form and complaint resolution process
- Nursing homes to establish and operate compliance and ethics programs

ENFORCEMENT

- CMS to revise civil monetary penalty (CMP) requirements
- CMS to establish 60-day notification of nursing home closures
- CMS to establish and fund national demonstration projects on culture change and the use of IT to improve resident care
- Nurse aides must be trained in dementia care and resident abuse prevention

Prevention of Abuse

- CMS to support development of state programs to conduct national criminal background checks
- Nursing homes, other long-term care facilities that receive federal funds, and their employees must report suspected crimes against residents to law enforcement

Quality Assurance and Performance Improvement (QAPI)

- DHHS is required to establish standards related to quality assurance and performance improvement and provide TA to facilities on the development of best practices in order to meet standards
- Each nursing home must submit to DHHS a plan for how the facility will meet the standards and implement best practices

Status – CMS To Date Has :

- Developed new Medicare cost reporting forms
- Improved collection of data on owners and managers
- Added new information on complaints and penalties to Nursing Home Compare
- Provided links to health inspection reports and a searchable database of owners and managers
- Developed a standardized complaint form
- Provided TA on quality assurance and improvement programs

Small Group Discussion

1. What are you hearing about the impact of PPACA and other reforms on the organizations with which you work?
2. What are the challenges they are facing?
3. What role can TEF play in helping members and the institutions where they work meet those challenges?

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

Report Out

POP QUIZ!!!

VALUE-BASED PURCHASING APPLIES TO WHAT FUNDING SOURCE?

A. MEDICAID

B. MEDICARE

C. BOTH MEDICAID AND MEDICARE

D. HOSPITAL DSH PAYMENTS

In FY 2014, WHAT MEASURES ARE INCLUDED IN VBP?

A. HCAHPS and Clinical Process Measures

B. Readmissions

C. HCAHPS, Readmissions, and Clinical Process Measures

D. HCAHPS, Clinical Process Measures, and Mortality Outcomes

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

WHAT HEALTH SYSTEMS DOES VBP APPLY TO?

A. NURSING HOMES

B. HOSPITALS

C. HOSPITALS AND NURSING HOMES

D. HOSPITALS AND OUTPATIENT CLINICS

IN FY 2015, WHAT OUTCOME MEASURES WILL BE INCLUDED IN VBP?

A. 30-Day Mortality Rate for AMI, PN, and HF

B. CLABSI

C. PRESSURE ULCER RATE

D. ALL OF THE ABOVE

What Efficiency Measure Will be Added to VBP in FY2015?

A. Medicare spending per Disease Episode

B. Return on Investment for Workforce Training

C. Cost of Hospital Acquired Conditions

D. Medicare Spending per Beneficiary

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

What Three 30-Day Readmission Conditions are Penalized Now?

A. AMI, PN, HF

B. HF, OCPD, AMI

C. Hip Replacement, HF, PN

D. AMI, UTI, PN

Which Organizations are Likely to be MOST Affected by the HAC Reduction Program?

A. Rural Hospitals

B. Urgent Care Centers

C. Teaching Hospitals

D. Small Hospitals (under 50 beds)

WHAT'S THE BOTTOM LINE?

A. Health Care Reform is impacting our members

B. Health Care Reform is impacting our institutions

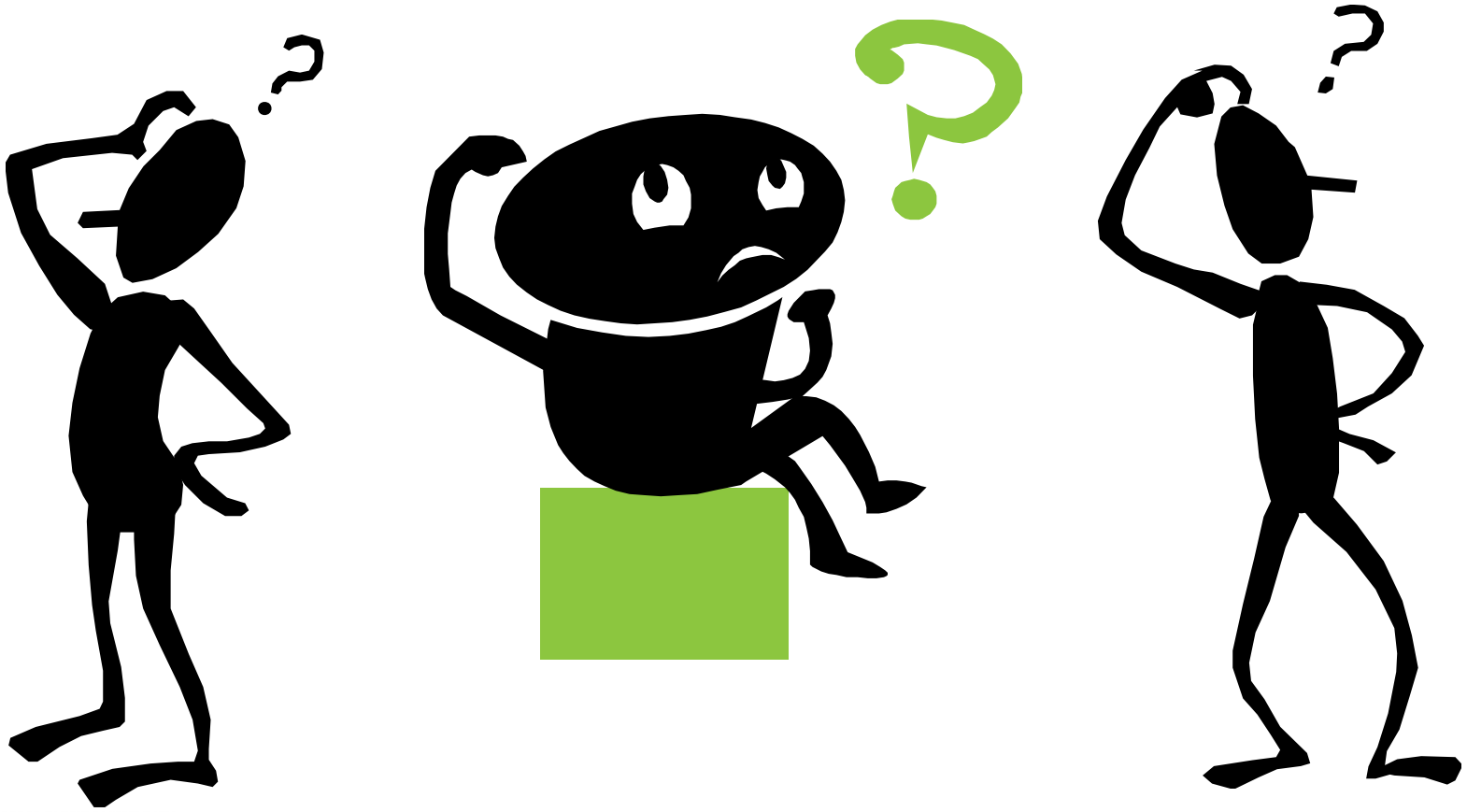
C. Health Care Reform is impacting our work in TEF

D. Health Care Reform is shifting the health care landscape

ALL OF THESE!!!

LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership

QUESTIONS?
THOUGHTS?



LABOR MANAGEMENT PROJECT
An employer and 1199SEIU partnership


Thank You!