How to Align Financial Performance and Quality:

Understanding pay-for-performance and new directions in financial reimbursement

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PricewaterhouseCoopers' Health Industries

Objectives for the Session

- Understand the state of quality in the US today and emerging improvement initiatives
- Understand the scope and implications of new CMS regulations governing pay-for-reporting, pay-for-performance, POA indicators, and MS-DRGs
- Discuss practical take-aways that help you address financial and operational implications
- Explore implications for the Florida marketplace

The Quality Landscape

The quality landscape

Quality	No quality
US is the global leader in Nobel prizes for medicine, with 12 to US scientists and 3 to foreigners in US, vs 7 abroad	US ranks lowest of developed nations in life expectancy and infant mortality
4 of 6 top innovations were developed in US: MRI/CT, statins, CABG, ACE inhibitors	55% of people get recommended care
NIH's research budget is $28 billion, vs. $3.7 billion for all EU	44-98,000 people annually die from preventable medical errors
	The average hospital patient experiences at least 1 medical error daily

The quality landscape

Quality Is Critical For A Sustainable Health System

Percent who said these rate 4 or 5 on a scale of 1 to 5 in terms of importance to sustainability

Source: HealthCast 2020 Survey

The quality landscape

Transferable Lessons

- Harmonize quality standards
- Make error reporting voluntary and anonymous
- Incentivize clinicians for outcomes, not activity, through pay-for-performance
- Publish or perish
- Leverage quality to move the market

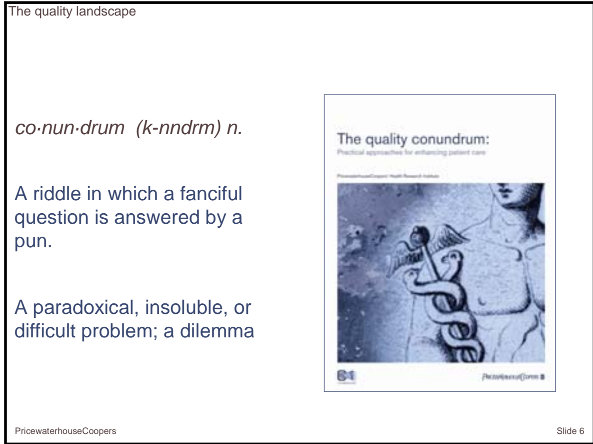
Source: HealthCast 2020 Survey

The quality landscape

co·nun·drum (k-nndrm) n.

A riddle in which a fanciful question is answered by a pun.

A paradoxical, insoluble, or difficult problem; a dilemma



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The quality landscape

Measuring Quality is Difficult and Involves Multiple Mandates

IOM's 6 Quality Aims	Airlines	Hotels	Banking	Education	Healthcare
Effective				X	X
Efficient		X	X		X
Equitable				X	X
Patient/customer-centered	X	X	X		X
Timely	X		X		X
Safe	X				X

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The quality landscape

Patients and Providers View Quality Differently

How important is it that…	Patient rankings	Doctor rankings
MD is skillful	1	1
MD is thorough	2	11
MD is truthful	3	4
MD take patient seriously	4	8
MD builds trust	5	2
MD gives facts about risks/benefits	6	58
MD answers questions	9	40
MD explains medications	12	82
MD's diagnosis makes sense	20	62
Chart is there	40	4
MD doesn't embarrass patient	60	13
Staff are polite	72	17
Information is given privately	80	10

Source: Presentation by Tom Delbanco, MD, Koplow-Tullis Professor of General Medicine and Primary Care, Harvard Medical School

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The quality landscape

More Consumers Are Using The Internet To Seek Healthcare Information

"Cyberchondriacs" represent 80% of all online adults. An estimated 136 million Americans search for health information electronically.

How are Healthcare Consumers using the Internet?

Use	Percent
Seek out the cost of treatment options	14%
Look for information that compares treatment options	39%
Search for treatment information	72%

Source: The Commonwealth Fund, "Mirror, Mirror on the Wall: An Update on the Quality of American Health Care Through the Patient's Lens", April 2006

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The quality landscape

Quality Has Been in the Eye of the Beholder

Top hospitals listings of various public sources

Solucient
* The Villages Regional Hospital

HealthGrades
* Baptist Hospital of Miami
* Delray Medical Center
* Holmes Regional Medical Center
* Holy Cross Hospital
* Lawnwood Regional Medical Center and Heart Institute
* Morton Plant Hospital
* Munroe Regional Medical Center
* Ocala Regional Medical Center
* Palm Beach Gardens Medical Center
* Sarasota Memorial Hospital

US News and World Report
* H. Lee Moffitt Cancer Center & Research Institute
* Sarasota Memorial Hospital
* University of Miami, Jackson Memorial Hospital
* Shands at the University of FL
* Bascom Palmer Eye Institute

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The quality landscape

March of the 900 lb. Gorilla Towards Pay-for-Performance

October 2003	April 2004	August 2006	July 2007	2009	2009
Medicare Modernization Act	**ONCHIT Formation**	**"Better Care, Lower Cost"**	**Physician Reporting**	**Outpatient Quality**	**Medicare Value Purchasing Act**
Reporting on 10 core measures for 0.4% payment update, up to 21 measures, 2% in '07. Patient satisfaction to be added on '08. hospitalcompare.hhs.gov	Executive Order establishing the goal of interoperable electronic health records within 10 years	Executive Order directing federal agencies to provide health care quality and price information hhs.gov/transparency	Voluntary program launched with 16 core measures. 1.5% payment bonus	CMS plans to develop measures specifically for hospital outpatient care	Bill proposing value-based payments

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The quality landscape

Many P4P Models are Emerging

CMS

Hospital Quality Initiative: 10 core measures

Premier Hospital Quality Incentive Demonstration Project : 34 measures

Physician Group Practice Demonstration

Chronic Care Improvement pilot

MMA section 649
MMA section 646

Private Sector

Bridges to Excellence
IHA
Leapfrog Group

Reductions in inpatient and ER utilization, costs

U.K Family Doctor Contract

104 different performance indicators

Of 1050 possible points, most practices are earning over 950, with expected scores around 750

20% pay raise for many physicians

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The quality landscape

In the Commercial Sector, Market Consolidation Enables P4P

Pay-for-Performance Readiness

Most Ready
Least Ready

Based on HealthLeaders ratings of degree of hospital, physician, and payer consolidation and Intel ratings of wired cities. More consolidated and wired markets are considered more "ready" for P4P. Circles are proportional to population size.

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The quality landscape

Where We Are: Mass Confusion?

You are here

FEDERAL
PUBLIC-PRIVATE
PRIVATE

CMS
AHRQ
AQA
NQF
HQA
Foundations
Health Insurers
NCQA
JCAHO
Other Professional Associations
Consumer Groups
Hospitals
Employer/ Business Groups
AMA Physician Consortium
Pharma Companies
Medical Associations
Leapfrog Group

Quality

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The quality landscape

Quality Measures Have More Questions Than Answers

- Should we measure structure, process, or outcomes?
- What do we do about small practices and outliers?
- Should we measure individual patients or populations?
- How do we measure care across settings?
- How do we reconcile data from different departments?
- Point in time vs. care across settings?

> *"Currently, we have a virtual soup of different measurement requirements."*
> Christine K. Cassel, M.D., president and CEO of the American Board of Internal Medicine

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The quality landscape

And What Should We Do About Shared Accountability?

Source: Report on Louisiana Healthcare Delivery and Financing System, PricewaterhouseCoopers, Report to Louisiana Recovery Authority, April 2006

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The quality landscape

Data on Quality is Not Necessarily Quality Data

GAO Report to the Committee on Finance, U.S. Senate

HOSPITAL QUALITY DATA

CMS Needs More Rigorous Methods to Ensure Reliability of Publicly Released Data

GAO

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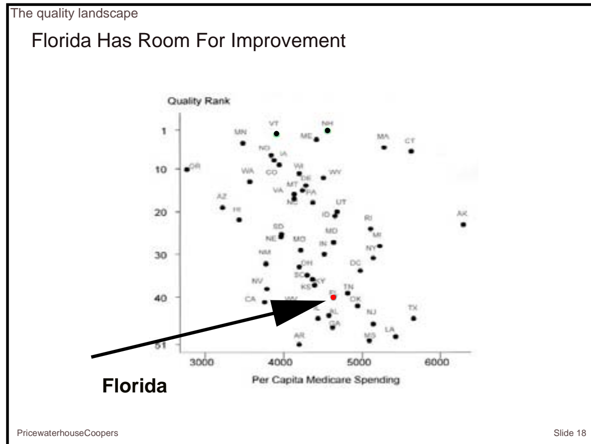
The quality landscape
Florida Has Room For Improvement
Quality Rank
Per Capita Medicare Spending
Florida
PricewaterhouseCoopers
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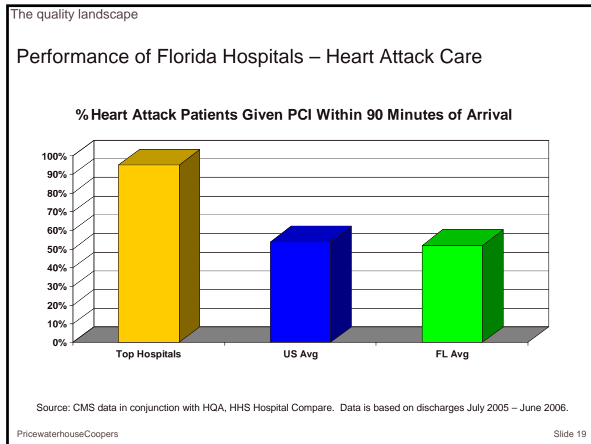
The quality landscape
Performance of Florida Hospitals – Heart Attack Care
% Heart Attack Patients Given PCI Within 90 Minutes of Arrival
Top Hospitals
US Avg
FL Avg
Source: CMS data in conjunction with HQA, HHS Hospital Compare. Data is based on discharges July 2005 – June 2006.
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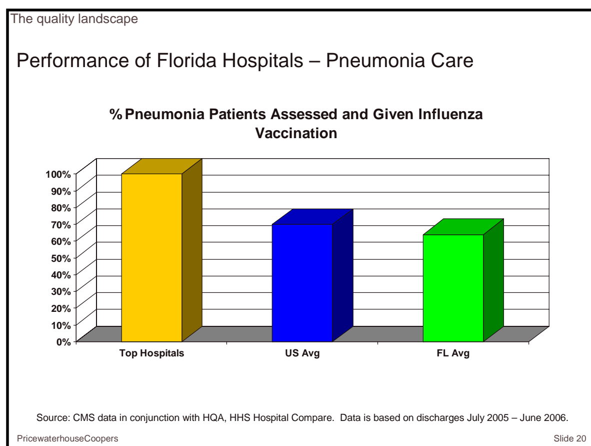
The quality landscape
Performance of Florida Hospitals – Pneumonia Care
% Pneumonia Patients Assessed and Given Influenza Vaccination
Top Hospitals
US Avg
FL Avg
Source: CMS data in conjunction with HQA, HHS Hospital Compare. Data is based on discharges July 2005 – June 2006.
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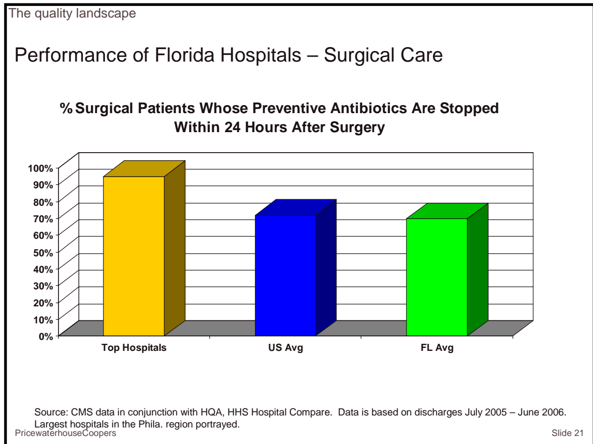
The quality landscape
Performance of Florida Hospitals – Surgical Care
% Surgical Patients Whose Preventive Antibiotics Are Stopped Within 24 Hours After Surgery
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Top Hospitals
US Avg
FL Avg
Source: CMS data in conjunction with HQA, HHS Hospital Compare. Data is based on discharges July 2005 – June 2006. Largest hospitals in the Phila. region portrayed.
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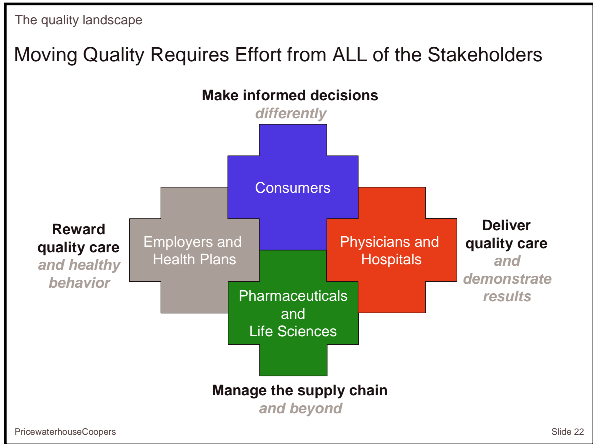
The quality landscape
Moving Quality Requires Effort from ALL of the Stakeholders
Make informed decisions
differently
Consumers
Reward quality care
and healthy behavior
Employers and Health Plans
Physicians and Hospitals
Deliver quality care
and demonstrate results
Pharmaceuticals and Life Sciences
Manage the supply chain
and beyond
PricewaterhouseCoopers
Slide 22

The quality landscape
Progress Will Require Efforts Within, Between, and Outside the Industry
Aviation's Training thru Simulations
Auto's Six Sigma and LEAN
Physician-Hospital Organizations
Accreditation/ Certification
Board, C-suite and CQO commitment
Industrial Engineers
RHIOs
Care Transaction Consortium
Local Collaborations
Retail's Service and Pricing
Manufacturing's "Stop the Line"
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Quality Reporting And Performance Tracking Requires Support From Health Information Technology

Computerized Physician Order Entry (CPOE) produces a 28% to 55% reduction in preventable prescribing errors.

CPOE costs ~$3 to $10 million per installation.

	Stand Alone Hospitals	Integrated Delivery Networks
Ambulatory CPOE	6%	10%
Inpatient CPOE	9%	15%

Source: Poon, E.G., et al. "Accessing the Level of Healthcare Information Technology in the US: A Snapshot", BMC Medical Informatics and Decision Making, Jan 2006

Where We're Going: Quality Reporting is Here to Stay

"The threat of consumer engagement and shedding light on performance will motivate the health system to change itself. Public reporting will be a stick for providers that don't do well but a carrot for those that do."
Maribeth Shannon, director of the hospitals and nursing homes program, California HealthCare Foundation

Pay For Performance

What Is Pay-For-Performance (P4P)?

"Pay-for-performance is a strategy to offer incentives to providers for delivering higher quality care as measured by selected evidence-based standards and procedures. Its goal is not simply to reward those who perform well or to reduce costs. Rather, it is a mechanism to align incentives to encourage ongoing improvement in a way that will ensure high-quality care for all."

What is Pay For Performance (P4P)?

Rooted in the Psychology of Behavioralism – people conduct their work based on what they are evaluated and reimbursed. i.e) "reward providers based on quality not on quantity".

P4P is a collaborative response to recent industry trends of:

1) a demand for cost reduction,
2) a call for improved service (consumerism), and
3) a need for accountability and payment based on measurable quality.

In other words, a "value based" healthcare system that focuses on price and quality

$$\textbf{Value} = \frac{\textbf{price}}{\textbf{quality}}$$

Why do we need Pay for Performance (P4P)?

The current Medicare payment system is broken. It provides few disincentives for overuse, under-use or misuse of care, and does not reward efficiency. Fundamental change requires a commitment by all Medicare providers to deliver high quality care efficiently.

Pay-for-performance constitutes *one* key component needed for the transformation of the health care payment system, but cannot achieve this transformation alone.

What is Driving Pay For Performance

Policymakers and payers are increasingly concerned that the U.S. pays more for health care…

Source: OECD Health Data 2005.

What is Driving Pay For Performance

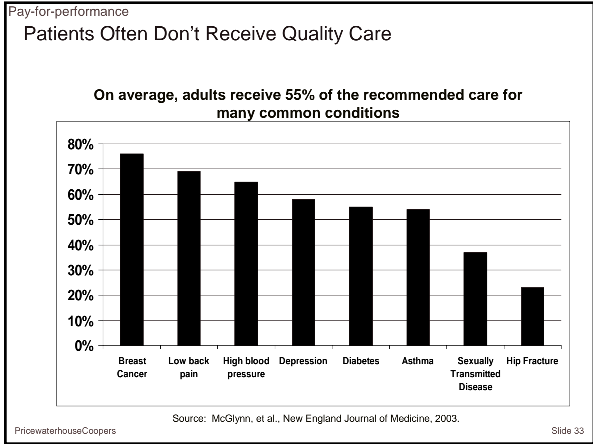
…Yet the U.S. achieves poorer results, compared to other major, developed countries.

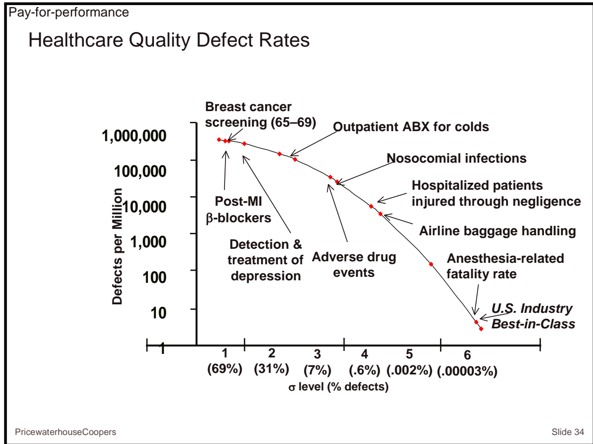
Source: OECD Health Data 2005.

Why Not the Best?: Results from a National Scorecard on U.S. Health System Performance

The nation's overall score across 5 broad categories was 66, with 100 being the top-performance score:

- Outcomes—69
- Quality—71
- Access—67
- Equity—71
- Efficiency—51





Pay-for-performance

Key Learning Points: What is Driving Pay For Performance

The Bottom Line:

1) The U.S. spends more money *per capita* on healthcare than any other country in the world
2) According to the World Health Organization (WHO) the U.S. healthcare system is ranked 37th out of191 countries in terms of QUALITY.
3) Consumers are concerned about quality outcomes and are increasingly involved in healthcare decisions due to:
   - The aging population
   - Increases in patient payments
   - A greater number of provider options
4) CMS has projected at the current rate of spending that the Medicare Trust Fund will be insolvent by 2018.

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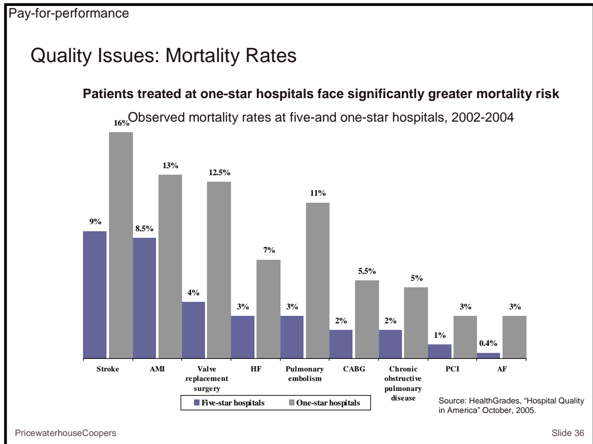

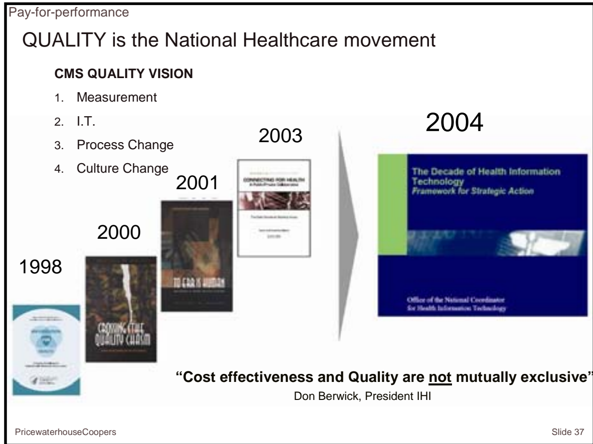

Pay-for-performance

Pay for Performance - Affecting Rate and Volume

Revenue = Rate X Volume

Rate
- **Pay for Reporting (current)**
  - Medicare Modernization Act - 0.4% impact on reimbursement for data reporting
- **Pay for Performance (2007)**
  - Medicare Value Purchasing Act – starting in 2007 will provide incentives and penalize hospitals based on quality indicators.
  - Incentive will begin at 1% and will scale up to 2% over 5 years.
  - Commercial plans are likely to follow close behind CMS.

Volume
- **Commercial payors are steering patients based on quality indicators and scores.**
  - e.g. Report carding

Transparency/Consumerism – Patients choose their hospital.

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Pay-for-performance

Shifting Patient Volumes based on Quality

Consumerism

26% of the adult population indicate that they are very likely to use hospital ratings data, with more than two-thirds indicating they would be willing to change providers / facilities if they had below average ratings.

Consumers hospital preferences / choices are likely to be swayed by facilities that provide centers of excellence (COE).

Likelihood of Using Rating Data For Family Member

18% 8% 30% 44%

Differentiating Among Available Hospitals

42% 29% 62% 43%

Solucient, LLC

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Pay-for-performance

The Healthcare Quality Continuum

High

\# of providers

Low

Low Performing: Meets requirements driven	**Average Performing:** Measurement driven	**High Performing:** Quality driven
▪ Licensing ▪ Regulation	▪ Measurements ▪ Public reporting ▪ Pay for performance	▪ Technology adopters ▪ Process redesign ▪ CEO-driven ▪ Culture of quality & continuous improvement

Quality

- Clinical performance
- Patient satisfaction
- Financial & operating efficiency
- Employee satisfaction

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Pay-for-performance

Current Policy and Legislation: The Medicare Value Purchasing Act (MVP) of 2005

- The Medicare Value Purchasing (MVP) Act of 2005 requires the Secretary of Health and Human Services (HHS) to develop and implement value-based purchasing programs
- Act applies to acute-care hospitals, physicians and practitioners
- The MVP Act sets aside 1.0 percent of Medicare payments from participating providers and increases this amount to 2.0 percent over five years.
- Monitored closely and likely increased significantly after 2012
- Critical vehicle in the transparency of quality
- The measure set will likely start small, but the sets would become more robust over time
- Measures are health care processes, structures, outcomes, patient experience of care, equity, efficiency, and the use of information technology. (consistent with HQA measures)
- POA collection mandated in 2007 – eliminate perverse incentives for Hospital acquired infections

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Pay-for-performance

Future Considerations

"Next 5 to 10 years, P4P could account for 20% to 30% of what federal government pays providers"

– Mark McClellan, 2005 in "Quality, Safety, and Transparency: A Rising Tide Floats All Boats"

"This is the beginning of the third wave of reimbursement, not some fad."

-Paul Danello, former counsel DHHS, OIG

Source: Med-Vantage Survey 2005

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Pay-for-performance

High Quality Hospitals Excel in Business

Solucient's 2005 Top 100 Hospitals list found that its benchmark hospitals did significantly better compared to their peers in several areas, including:

- 16.66% lower mortality
- 15.69% lower complication rates
- 9.33% shorter ALOS
- 8.83% lower expenses per discharge
- More than three times the profitability (8.08% vs. 2.56%) compared to non-benchmark peers
- Increased growth of 7.82% compared to a slight increase in growth of 2.63% for peers

Source: Solucient Top 100 Hospitals: National Benchmarks for Success 2005 (Evanston: Solucient, 2006) 31.

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Pay-for-performance

Clinical Strings

The direct link between quality outcomes and improved financial performance.

Quality Indicator	Operational Indicator	Financial Indicator
Patient Satisfaction ↑	Average Length of Stay ↓ Cost per Discharge ↓	Operating Margin ↑ Contribution Margin ↑
Mortality Rates ↓	Average Length of Stay ↓ Cost per Discharge ↓	Operating Margin ↑ Contribution Margin ↑
Reduced Operator Variability in Treatment ↓	Average Length of Stay ↓ Cost per Discharge ↓ Mortality ↓	Utilization of Medical Resources, Staff, and Supplies ↑ ↑
Improved Outcomes ↑	Improved CMS and Commercial payer compliance ↑ ↑	Operating Margin ↑ Contribution Margin ↑

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Pay-for-performance

Acute Care Example: CMS/Premier

The Centers for Medicare and Medicaid Services (CMS) has several ongoing demonstration projects

Premier- CMS Pilot (3 year)

- bonuses for hospital-based performance in 5 areas, including heart attack, heart failure, and coronary artery bypass graft surgery.
- Hospitals will be scored & ranked by condition, with the top 10% receiving a 2% bonus on Medicare payments. Top 11-20% will receive 1% bonus.
- hospitals not meeting a predetermined score on quality measures will be subject to reductions in payment. (budget neutral)

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Pay-for-performance

Quality care costs less: Premier Demo. Project Results

Hospital costs for pneumonia patients

Average Hospital Costs

$12,000
$8,000
$4,000
$0

$10,298
$9,158
$8,412

Low (0% to 49%)
Medium (50% to 74%)
High (75% to 100%)

Patient Process Measure

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Pay-for-performance

Quality care lowers mortality rates: Premier Demo. Project Results

Mortality rate of Heart bypass surgery patients (%)

Mortality Rate

15%
10%
5%
0%

11.0%
6.2%
1.6%

Low (0% to 49%)
Medium (50% to 74%)
High (75% to 100%)

Patient Process Measure

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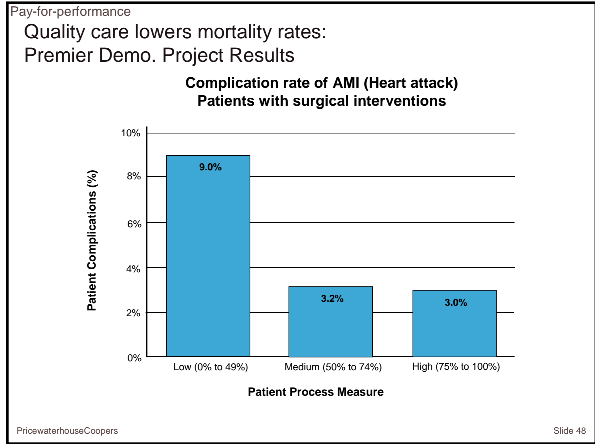
Pay-for-performance
Quality care lowers mortality rates:
Premier Demo. Project Results
Complication rate of AMI (Heart attack)
Patients with surgical interventions
Patient Complications (%)
10%
8%
6%
4%
2%
0%
9.0%
3.2%
3.0%
Low (0% to 49%)
Medium (50% to 74%)
High (75% to 100%)
Patient Process Measure
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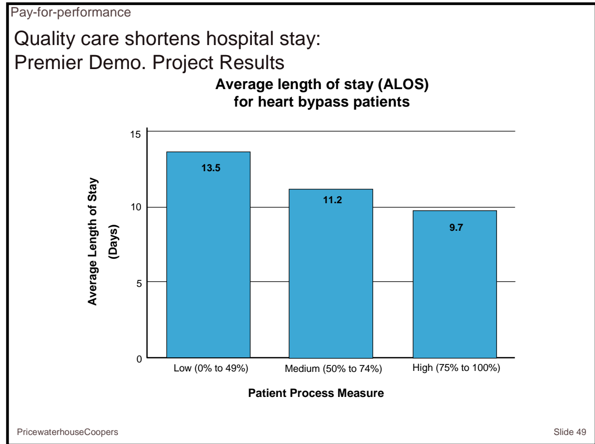
Pay-for-performance
Quality care shortens hospital stay:
Premier Demo. Project Results
Average length of stay (ALOS)
for heart bypass patients
Average Length of Stay
(Days)
15
10
5
0
13.5
11.2
9.7
Low (0% to 49%)
Medium (50% to 74%)
High (75% to 100%)
Patient Process Measure
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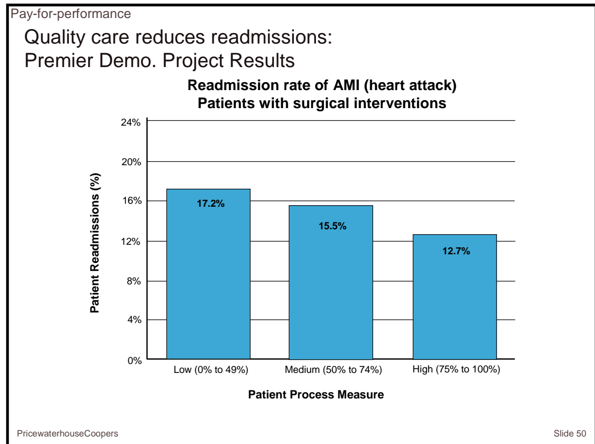
Slide 49


Pay-for-performance
Quality care reduces readmissions:
Premier Demo. Project Results
Readmission rate of AMI (heart attack)
Patients with surgical interventions
Patient Readmissions (%)
24%
20%
16%
12%
8%
4%
0%
17.2%
15.5%
12.7%
Low (0% to 49%)
Medium (50% to 74%)
High (75% to 100%)
Patient Process Measure
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Slide 50

Pay-for-performance

Office Based Example - Medicare Care Management Performance Demonstration

~ 800 practices participating in DOQ-IT project in four states

- Arkansas
- California
- Massachusetts
- Utah

Technical assistance to physician practices by QIO's

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Pay-for-performance

Medicare Care Management Performance Demonstration

Pay for performance for physicians who:

- Achieve quality benchmarks for chronically ill Medicare beneficiaries
- Adopt and implement practice standards to promote care management and coordination

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Pay-for-performance

Industry Lead Example - Bridges to Excellence

Diabetes Care Link

Using Evidence-Based Literature and Actuarial Analysis

Diabetes

- **Quality Care Saves $350/Diabetic/Year**
  - **Purchaser Keeps $175**
  - **Physicians Get $100/Patient Incentives $75**

All Payers:
For Practice with 100 Diabetics - $10,000/Year
For Diabetes Clinic with 1,000 Diabetics - $100,000/Year

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Pay-for-performance

The Practitioner Perspective

Physicians are feeling the P4P pressure more than any other stakeholder at this point.

Physicians in turn are pressuring hospitals to provide the highest opportunity for clinical success. Quality data has already become a facility differentiator that directly impacts the bottom line of practitioners. Additionally, they will continue to be the primary influence on consumer choice and can become an advocate for top performing facilities.

Physician recognition programs are an important driver for payer relations

- Achieving quality standards for inclusion in public directories, etc
  - NCQA's Bridges to Excellence directory
- Market differentiation and distinguisher

Physicians are beginning to seek out comparative quality data as their pay becomes tied to performance.

Pay-for-performance

What is Driving Pay For Performance

Pay-for-performance

Physician-Hospital Collaboration Demonstration

A three-year demonstration program, announced September 6,2006, to examine whether allowing hospitals to provide financial incentives for physicians to support better care can improve patient outcomes without increasing costs

Hospital to be paid its usual inpatient rate for the patient's care, but would pay the physician a portion of the savings resulting from quality improvement and efficiency initiatives taken by the physician

Pay-for-performance

Physician-Hospital Collaboration Demonstration

Focus on the entire scope of health care for a surgical episode or other episode of illness involving hospital care.

Requires tracking patients for an entire episode of care, which generally extends well beyond a hospitalization, to determine the impact of hospital-physician collaborations on preventing short and longer-term complications, duplication of services, coordination of care across settings, and other quality improvements

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Pay-for-performance

Physician-Hospital Collaboration Demonstration

"The most costly and intensive physician services are provided in hospitals, yet our payment systems do not support steps by hospitals and doctors to work together to improve care. This demonstration program will support efforts to track and improve the overall episode of patient care, including follow-up and longer-term outcomes."

-CMS Administrator, Mark B. McClellan, M.D., Ph.D.

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Pay-for-performance

The "How's"

Priority of executive team

- Quality needs to be the number one priority with senior leadership, with strong Board support
- Needs to be driven by leaders' vision
- Incentives based on quality outcomes
- People pay attention to what the leaders pay attention to. Urgency and priority are well understood by the rest of the organization.
- CEO articulates the importance of quality at new employee orientation

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Pay-for-performance

The "How's"

Physician engagement

- Physician-driven process to enhance clinical care
- Physician chair on all performance improvement teams— "TEAMS are the key"
- Share data with physicians

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Pay-for-performance

The "How's"

Improvement methodology

- Gives you the language for improvement
- Keeps you on track and prevents going down the wrong path
- Adds "method to the madness"
- Focus on "systems improvement"
  - Provide process management tools

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Pay-for-performance

The Strategic Fit of Pay-For-Performance

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Operational Take Aways for Pay for Performance

- ✓ Examine data collection and coding processes within your organization
- ✓ Analyze your data for accuracy
- ✓ Focus on physician documentation especially focusing on POA indicators and the accuracy of identifying these indicators
- ✓ Focus on “systems improvement”
  - ✓ Evaluate operational processes

Other Payment Reform Initiatives: POA and MS-DRGs

Present on Admission (POA) Reporting Requirements

CMS mandated reporting under the Deficient Reduction Act of 2005 effective October 1, 2007. AHCA requires reporting of POA indicators as of January 1, 2007. Projected benefits include:

1. Add precision to ICD-9-CM coding to distinguish between pre-existing conditions and complications
2. Increase efficiency of hospital QA by decreasing false positives requiring further review
3. Increase accuracy of safety and quality of care measures
4. Increase validity of hospital report cards
5. Increase accuracy of results in mortality and risk assessment
6. Improve design and fairness of pay for performance programs

POA requirements

Present on Admission Reporting Requirements/Challenges

- HIM professionals must “tag” principal and secondary diagnoses with indicators of “uncertain”, “present on admission” and “not present on admission”
- Challenges abound in clarity of physician documentation to make this determination
- HIM access to physician advisors to assist in this review is many times limited
- Coding guidelines sometimes conflict with core measures reporting --- must be clearly documented to be reported
- Communication between quality management and HIM is imperative for collaboration in working with physicians, improving data accuracy and achieving optimal performance measures

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POA requirements

Poor Coding Quality Has Organizational Risks

- P4P Rate reduction
- Volume and market share loss
- Compliance reporting and regulations
- Perceived lower quality - Reputation
- Extension to consumerism and commercial markets

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POA requirements

Present on Admission Requires Operational Focus

- Communication between quality management and HIM is imperative for collaboration in working with physicians to improve data accuracy
- Access of HIM to a physician advisor
- Review of POA indicator data to determine the percentage of cases “tagged” in the various review categories
- Integrate concurrent POA review to improve documentation and educate physicians – can be performed with Case Management, Utilization Management or Documentation Specialists

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POA requirements

POA - Future Implications

- The Deficit Reduction Act of 2005 requires the Secretary of Health and Human Services to select at least two conditions that:
  - Are high cost, high volume, or both
  - Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis
  - Could reasonably have been prevented through the application of evidence-based guidelines by October 1, 2007
- For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission.

POA requirements

POA - Future Implications (continued)

- CMS is proposing the selection of six conditions that, starting in FY 2009, would not trigger a higher DRG unless they are present on admission:
  - Catheter-associated urinary tract infections
  - Pressure ulcers (decubitus ulcers)
  - Staphylococcus aureus septicemia
  - Object left in surgery
  - Air embolism
  - Blood incompatibility
- Although hospitals would have to start reporting whether these conditions are present on admission for FY 2008, they would not affect reimbursement until FY 2009.

MS-DRGs

Proposed Medicare Severity DRGs (MS-DRGs)

- CMS proposed to replace the current DRG system with a modified version of the Yale University 1994 Severity DRGs
- Final report due to CMS on 9/1/07 by the RAND Corporation who is evaluating various severity based DRG systems

MS-DRGs

How MS-DRGs Work

- 745 new severity adjusted DRGs will replace the existing 538 CMS DRGs to more adequately capture severity of illness of patients
- Diagnosis codes are subdivided into three different levels of CC severity: major CC (MCC), CC, and non-CC. Diagnosis codes classified as MCCs reflect a higher level of severity than those classified as CCs. Secondary diagnoses that are classified as non-CCs do not affect the DRG assignment
- All secondary diagnoses are evaluated as to their impact on increased hospital resources to warrant “sub-dividing” MS-DRGs into groups of CCs as described above

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MS-DRGs

How MS-DRGs Work (continued)

- In designating a proposed MS-DRG as one that will be subdivided into subgroups based on the presence of a CC or MCC, CMS developed a set of criteria that will have to be met in order to warrant creation of a CC or MCC subgroup within a base MS-DRG:
  - **A reduction in variance of changes of at least 3 percent.**
  - **At least 5 percent of the patients in the MS-DRG fall within the CC or MCC subgroup.**
  - **At least 500 cases are in the CC or MCC subgroup.**
  - **A minimum 20 percent difference in average charges between subgroups.**
  - **A $4,000 difference in average charges between subgroups.**

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MS-DRGs

How MS-DRGs Work (continued)

- As a result of applying these criteria, a base MS-DRG may be subdivided in one of three ways:
  - DRGs with subgroups (MCC, CC, and non-CC)
  - DRGs with two subgroups consisting of an MCC subgroup but with the CC and non-CC subgroups combined (these groups are referred to as "with MCC" and "without MCC")
  - DRGs with two subgroups consisting of a non-CC subgroup but with the CC and MCC subgroups combined (these groups are referred to as "with CC/MCC" and "without CC/MCC")

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Proposed MS-DRGs by CC subgroup

Subgroups	# of Proposed Base MS-DRGs	# of Proposed MS-DRGs
No Subgroups	53	53
Three subgroups	152	456
Two subgroups; major CC and cc; non-CC	63	126
Two subgroups; non-CC and CC; major CC	43	86
Subtotal	**311**	**721**
MDC 14 (Births)	22	22
Error DRGs	2	2
Total	**335**	**745**

Source: CM 1588-P, page 109, Table K—Number of CC Subgroups

Projected Impact of MS-DRGs

- Current system:78% of DRGs have CCs and 22% are non-CC cases
- Using three severity subclasses in the MS-DRG system to FY 2006 data would result in:
  - **22 percent of patients being assigned to the severity subgroup with the highest level of severity (MCC),**
  - **41 percent assigned to the lowest severity subclass (non-CC),**
  - **37 percent assigned to the middle severity subclass (CC).**
- CMS believes the adoption of the MS-DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding.

Projected Impact of MS-DRGs

- Coding that has no effect on payment under the current CMS DRGs may result in a case being assigned to a higher-paid DRG under the MS-DRGs.
- CMS believes an adjustment to the standardized payment amount is warranted in order to eliminate the effect of changes in coding or classification of hospital discharges that do not reflect real changes in case mix. Given the similarity between coding incentives using the APR-DRGs in Maryland and the proposed MS-DRGs, CMS analyzed Maryland data to develop an adjustment for improvement documentation and coding.
- As a result of this analysis, CMS is proposing to reduce the IPPS standardized amounts by 2.4 percent each year for FY 2008 and FY 2009.

MS-DRGs

Operational Implications of MS-DRGs

- Physician documentation of pertinent diagnoses will be key to achieving accurate reimbursement under MS-DRGs
- HIM professionals will be instrumental in achieving accurate reimbursement
  - **Credentialed coders**
  - **Ongoing coding and physician education**
  - **Strong quality review processes**
  - **Data integrity reviews**
- Physician query processes will need to be increased and strengthened to allow clarification of any documentation discrepancies
  - Consider integration into physician bylaws
- Collaboration between coding and quality measure processes will be needed to achieve optimal results

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Conclusion

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Conclusion

Implications for Florida Hospitals

- In the future, quality will drive market reputation and financial success
- To succeed in the new environment, hospitals will need to undertake or consider formal approved strategies that align physicians and hospitals based on quality and performance (operational and clinical) metrics
- They will need to enhance and integrate their care management, clinical documentation, patient safety, coding, and financial reporting practices
- This will require new relationships, roles and responsibilities
- Reporting is just one small element of the new organizational mindset that will be needed

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Conclusion

Finding A Strategy to Deal With The 3rd Wave of Reimbursement

Measurement is necessary but not sufficient. Additional changes are required:

1. Leadership and culture dedicated to a change management approach and framework
2. Organizational structure and resources
3. Commitment to data reporting and integrity
4. Process linkages and redesign
5. Supporting technology infrastructure

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Conclusion

And Last but Not Least…

6. Sustain focus.

> *"Healthcare has a history of a 'philosophy du jour'. We need to learn how to sustain focus. We don't suffer from an absence of ideas. We suffer from an absence of will and execution."*
> James Conway, senior fellow of the Institute for Healthcare Improvement and senior consultant of the Dana-Farber Cancer Institute.

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