

Healthcare Reform: Improving Quality & Patient Safety



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Centers for Medicare & Medicaid Services (CMS)
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No Conflicts To Declare

Centers for Medicare & Medicaid Services (CMS)

- Will provide health benefits for over 114 million Americans in FY 2011 PP Budget
 - Medicare – 48.1 million beneficiaries
 - Medicaid – 56.1 million beneficiaries
 - CHIP – 10 million beneficiaries
- Will spend \$784 billion in FY 2011 PP Budget
 - Medicare - \$476 billion
 - Medicaid - \$297 billion
 - CHIP - \$11 billion

Ongoing CMS Core Work

- Provider payment-focused activities
 - Efficient, timely, accurate payment of claims
 - Ongoing demonstrations and pilots of alternative payment methodologies and systems
 - Addressing fraud & abuse
- Beneficiary focused activities
 - Benefit education
 - Health promotion and disease management education
 - Beneficiary protection and advocacy
- Multiple strategies to improve quality, efficiency and value

CMS: Our Aims

1. Excellence in Operations

Customer Focus

“Be what you wish to see in the world”

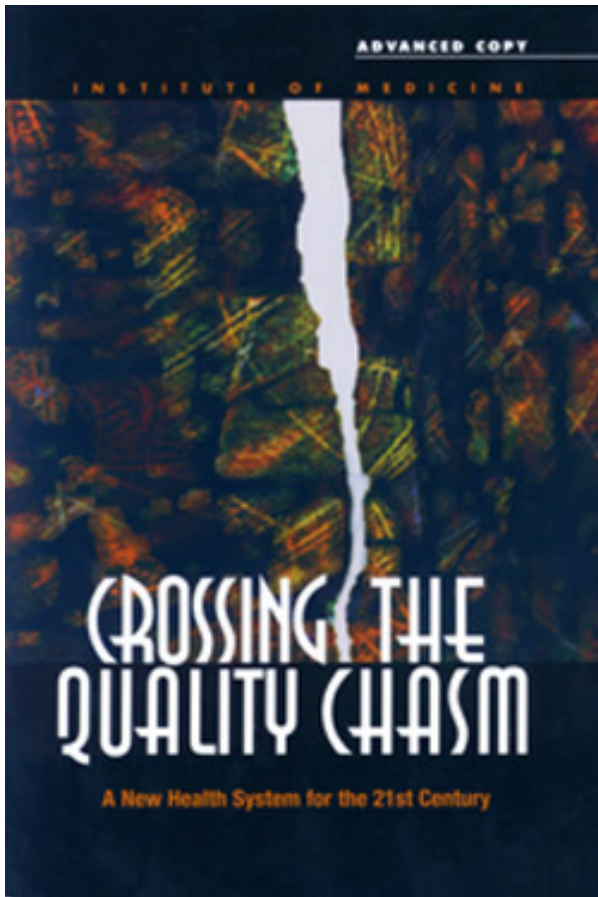
2. Focus on Quality of Care and on Patients

The Institute of Medicine’s “Six Aims for Improvement”

3. Focus on Integration of Care and Population Health

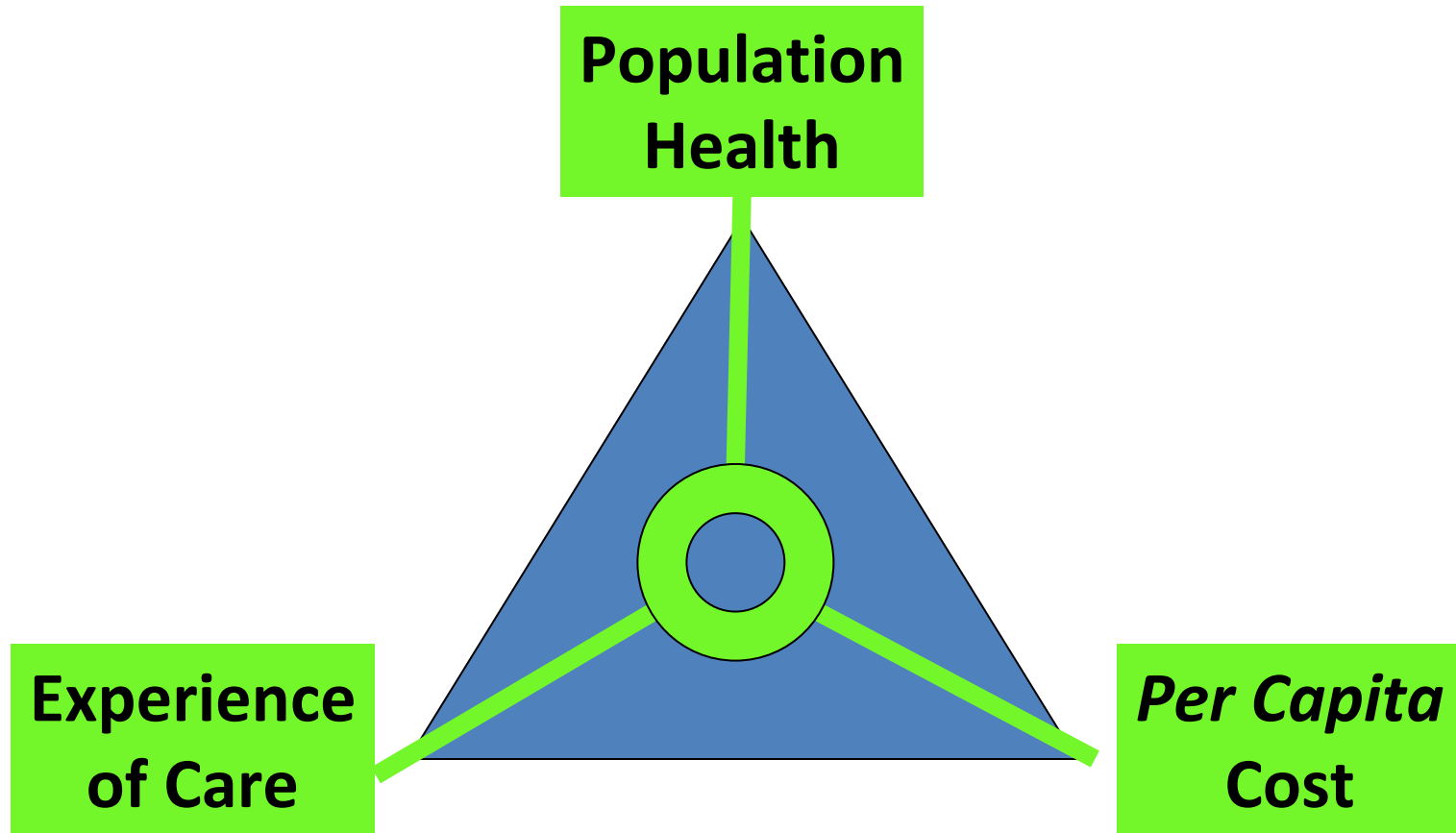
The “Triple Aim”

IOM Aims for Quality Improvement



- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity

The “Triple Aim”



NPP Priorities

- Patient & Family Engagement
- Population Health
- Safety
- Care Coordination
- Palliative and End-of-Life Care
- Overuse

Ensuring Quality & Value: CMS Tools

- “Contemporary Quality Improvement”
- Transparency: Public Reporting & Data Sharing
- Incentives:
 - Financial: Value-Based Purchasing, P4P, P4R, gain-sharing, ACOs, etc.
 - Non-financial
- Regulatory vehicles
 - COPs & CfCs
 - Survey & Certification, Accreditation
 - Myriad policy decisions: Benefit categories, Fraud & Abuse, etc.
- National & Local Coverage Decisions
- Demonstrations, pilots, research

“Contemporary” Quality Improvement

- Need to set priorities, goals and objectives, strategic framework first
- Evidence-Based goals, metrics, interventions, evaluations
- Rapid-cycle development, implementation and change methodology
- Leveraging of resources and efforts: Current and future models
- Many examples: QIOs, ESRD Networks, IHI, Bridges to Excellence, NCQA, Nursing & Home Health Campaigns, etc.

Transparency: Public Reporting & Data Availability

- CMS Compare Websites
 - Hospital Compare
 - Nursing Home Compare
 - Home Health Compare
 - Dialysis Facility Compare
 - MA Health Plan and Medi-Gap Compare
 - Prescription Drug Plan Compare
 - New under ACA
 - Physician Compare
 - VBP Programs: Above plus ASCs
 - LTCHs, IRHs, Hospices
- MyMedicare.gov
- HHS/CMS Data Dissemination Efforts: www.data.gov,
www.healthcare.gov



Incentives

- Current: Reporting and Adoption Programs
 - P4R: RHQDAPU, HOPQDRP, PQRI, e-Prescribing
 - ARRA/HITECH: EHR adoption and “meaningful use”
- Value-based Purchasing (VBP)
 - Hospital VBP Report to Congress (Nov 2007)
 - Physician VBP RTC due May 2010
 - ESRD Quality Incentive Program January 1, 2012
 - Hospital VBP (ACA Section 3001) by January 1, 2013
 - ACA mandates VBP in many additional settings
- Competitive bidding, gainsharing, shared savings, ACOs, medical homes, etc.

Regulation

- Conditions of Participation or Conditions for Coverage
 - COPs are minimum health and safety standards set by CMS for facilities that may receive Medicare payments
 - 17 separate provider settings plus supplier settings each have COPs
- Survey & Certification
 - All U.S. healthcare facilities certified by Medicare are expected to be in compliance with all current regulations, as well as applicable state laws
 - S&C process uses interpretive guidelines to assess compliance with regulations
- In combination, a powerful tool for quality/value
 - Measures can include regulatory metrics as well as “quality”

Other Strategies Tools

- National Coverage Decisions
 - Deciding whether a device, service or therapy is paid for (or not) can influence quality of care
 - E.g., Non-coverage of “Never Events” for both hospitals or physicians
 - E.g., limitation of services to “qualified” facilities or providers, such as ICD implantation, etc.
 - CED and use of registries collects further quality information
- Demonstrations, pilots, research
 - Numerous CMS Demonstrations in past and now following ACA implementation assessing payment systems and their effect on quality-Center for Medicare & Medicaid Innovation

Affordable Care Act (ACA) of 2010

- Patient Protection & Affordable Care Act (PPACA)
- Health Care & Reconciliation Act of 2010 (HCRA)
- Affordable Care Act of 2010 (ACA)

Affordable Care Act (ACA) of 2010

- Title I: Quality, Affordable Health Care for all Americans
- Title II: Role of Public Programs
- Title III: Improving the Quality & Efficiency of Health Care
- Title IV: Prevention of Chronic Disease & Improving Public Health
- Title V: Health Care Work Force

Affordable Care Act (ACA) of 2010

- Title VI: Transparency and Public Reporting
- Title VII: Improving Access to Innovative Medical Therapies
- Title VIII: Community Living Assistance Services & Support (CLASS) Act
- Title IX: Revenue Provisions
- Title X: Strengthening Quality, Affordable Health Care for All Americans (Amendments)

Patient Safety Sections in ACA

- Title I:
 - Ensuring Quality of Care in Individual and Group Health Plans by use of best practices, EBM, HIT, etc.
 - Increased reimbursement or incentives for patient safety initiatives
- Title III:
 - Mandated study on expanding Hospital Acquired Conditions (Patient Safety) beyond hospital setting

Patient Safety Sections in ACA

- Title III (continued)
 - National Priorities & Strategic Framework mandated to include patient safety, alignment of public/private
 - PSOs to assist hospitals with high readmission rates as part of their patient safety charge
 - Performance bonuses for MA plans improving patient safety
 - Research on patient safety
 - Integration of quality & patient safety topics in healthcare work force training

Patient Safety Sections in ACA

- Title VI: Transparency and Program Integrity
 - Disclosure by hospitals if physician not on duty in the hospital
 - Grants for EHR testing of Patient Safety measures in LTCFs
 - Sense of the Senate on Malpractice Issues
 - State Demonstrations on Malpractice Issues

Improving Medicare

- National Strategy for Quality Improvement in Health Care (Section 3011, with amendment 399HH)
 - National priority setting & strategic plan by 1/1/2011
 - Priority requirements
 - Improve outcomes, efficiency, patient-centeredness for all populations
 - Identify areas with potential for most rapid improvement
 - Address gaps in quality, efficiency and comparative effectiveness
 - Enhances data use for quality, efficiency, transparency, outcomes
 - High-cost chronic diseases, preventable admissions & readmissions, patient safety, medical error reduction, HAIs, health disparities, others as determined by Secretary
 - Website with priorities, agency plans, updates

Improving Medicare

- Inter-Agency Work Group on Health Care Quality (Section 3012)
- Quality Measurement Development (Section 3013)
 - Outcomes, Efficiency
- Quality Measurement by Consensus-Based Endorsement Body (Section 3014)
 - Multi-stakeholder group input
 - Dissemination by Secretary
- Data Collection & Public Reporting (Section 3015 with multiple amendments)
 - Clear public plan for data collection and public reporting developed 2010-2014

ACA: Improving Medicare

- Hospital Value-Based Purchasing Program (Section 3001)
 - Start FY2013
 - Mandatory Quality Measures Topics
 - Outcome: AMI, CHF, Pneumonia
 - SCIP
 - HAIs
 - HCAHPS
 - Efficiency measures
 - Public reporting on Hospital Compare website
 - VBP demonstrations for CAHs and small hospitals

ACA: Improving Medicare

- Improvements to PQRI (Section 3002)
 - PQRI extended to 2014 with bonus payments:
 - 2011: 1.0%
 - 2012-2014: 0.5%
 - Reductions in fee schedule for failure to report:
 - 2015: 1.5%
 - 2016 and beyond: 2.0%
 - Maintenance of Certification Program (MOCP) Incentive
 - Integration of PQRI and HITECH EHR reporting
 - Timely feedback reports
 - Informal appeals process

ACA: Improving Medicare

- Improvements to Physician Feedback Program (Section 3003)
 - Confidential resource use reports based on claims data to physicians
 - May include linked quality data
 - Episode groupers by 2012
 - Risk adjustment: Socioeconomic, geographic, race & ethnicity, health status, etc.
 - Public availability of methodology
 - Coordination with VBP programs

ACA: Improving Medicare

- Quality reporting for LTCHs, Inpatient Rehabilitation Hospitals, Hospices (Section 3004)
 - Quality measures development with required reporting
 - Reduction of payment methodology by 2.0% for failure to report starting 2014
- Quality reporting for PPS-exempt cancer hospitals (Section 3005): Starts 2014
- VBP program for SNFs, HHAs, ASCs (Section 3006)
 - Report to Congress by January 1, 2011

ACA: Improving Medicare

- VBP modifier under PFS (Section 3007)
 - Quality compared to costs
 - Budget neutrality specified
 - Rulemaking during 2013, implementation 2015
- Payment adjustment for conditions acquired in hospitals (Section 3008)
 - 1% payment reduction for HACs starting 2015
 - Risk adjustment required
 - Public reporting required
 - Study with RTC by 1/1/2012 on extending to other providers

Improving Medicare

- CMS Innovations Center by 2011 (Section 3021)
 - Develop patient-centered payment models
 - Encourage evidence-based, coordinated care for Medicare, Medicaid, CHIP
 - Rapid piloting/testing of new payment programs
 - Medicare Shared Savings Program (ACOs)
 - National Pilot Program on Payment Bundling
 - Independence at Home Demonstration
 - Hospital Readmissions Reduction Program
 - Community-Based Care Transitions Program
 - Extension of Gainsharing Demonstration

Accountable Care Organizations (ACOs)

- Pediatric Accountable Care Organization Demonstration Project (Section 2706)
- Medicare Shared Savings Program (Section 3022)
- Health Homes
- Models will rely on lessons learned from the CMS Physician Group Practice Demonstration

Conclusions

- CMS Statutory Authority provides powerful tools to focus on improving quality, value & patient safety
 - QI by providers, payers, collaboratives, others
 - Transparency: Public Reporting and Data Dissemination
 - Incentives
 - Regulatory compliance
 - Coverage, benefit, and utilization purposes
 - Research and Demonstrations

Conclusions

- The Affordable Care Act adds specific mandates and statutory authority that provides, for the first time ever, an opportunity for all healthcare stakeholders to:
 - Set priorities
 - Define a strategic framework to achieve specific goals and objectives
 - Collaborate & Leverage resources, efforts, knowledge, influence
- Patient Safety is clearly a priority coming out of

ACA

What is the Spectrum of “Patient Safety”?

- What are the key issues of “Patient Safety” to be addressed?
 - Certainly “To Err is Human” sets the best overview & framework
 - Issues still not addressed
- HHS OIG: Adverse Events in Hospitals
 - May be one of many reports which we can use to move forward

HHS OIG: Adverse Events in Hospitals

- Overview of Key Issues (December 2008)
- Case Study Incidence among Medicare beneficiaries in 2 selected counties (Dec 2008)
- State Reporting Systems (Dec 2008)
- Methods for Identifying Events (March 2010)
- National Incidence Among Medicare Beneficiaries (Pending, release soon)

OIG-Adverse Events in Hospitals: Overview of Key Issues

- Estimates of the incidence of adverse events in hospitals vary widely and measurement is difficult
- Nonpayment policies for adverse events are gaining in prominence and are viewed as a potential powerful incentive to reduce incidence, but raise potential drawbacks
- Hospitals rely on staff and managers to report adverse events internally, but barriers can inhibit reporting

OIG-Adverse Events in Hospitals: Overview of Key Issues

- Hospitals report adverse events to various oversight entities, although stakeholders suspect substantial underreporting
- Public disclosure of adverse events can benefit patients, but also raises legal concerns for patients and providers
- Information to help prevent adverse events is widely available, but some hospitals and clinicians may be slow to adopt or routinely apply recommended practices

OIG-Adverse Events in Hospitals: Overview of Key Issues

- Interviews and literature reveal strategies that may accelerate progress in reducing the incidence of adverse events in hospitals
 - National Body to lead patient safety efforts?
 - Focus on hospital use of guidelines & best practices
 - Establish methods of measuring incidence of adverse events
 - Expand use of EHRs
 - Monitor impact of financial incentives on reducing adverse events
 - Improve adverse event reporting, streamline & reduce burden

Final Conclusions

- In implementing the ACA, we will focus on patient safety as a key priority
- Issues needing resolution
 - Measurement/Metrics
 - Data sources, collection and reporting processes
 - How much should CMS and others use the CMS “Six Tools” for enhancing quality and value?
 - Evidence-based interventions: What works and what else do we need to know?
 - How do we all align efforts on which priorities?

Contact Information

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