Pay for Performance for the Hospital and Physician

Patrick J. Torcson, MD, MMM, FACP, SFHM
ptorcson@stph.org

(No Disclosures)
P4P for the Hospital and Physician

- The CMS/Medicare P4P Agenda
- Hospital-Level P4P:
  - Hospital Value-Based Purchasing Program
  - Readmissions Reduction Program
  - Hospital Acquired Conditions Reduction Program
- Physician-Level P4P:
  - Physician Quality Reporting System
  - Value-Based Payment Modifier
- Conclusions
Case Presentation

CC: Left arm and left leg weakness
HPI: 83-y.o. female, nursing home resident. Hospitalized 3 weeks prior with pneumonia and new onset a fib. Discharged on abs, diltiazem and warfarin. Anticoagulation discontinued 1 week pta because of hematuria. On day of admission woke up with arm and leg weakness and was sent to ED via ambulance.
Case Presentation (cont.)

PMH
1. CAD: remote CABG, PCI TNTC
2. ICM: EF 35% by echo 3 wks ago
3. Hypertension
4. DM Type II
5. Hyperlipoproteinemia
6. Gen OA, TKRs and THRs

SH Former smoker. Widow. Lives in NH X 5 yrs

Meds diltiazem, clopidogrel, atorvastatin, lisinopril, sitagliptan, metformin, furosemide, albuterol, hydrocodone, carvedilol

ROS Non ambulatory, urinary catheter placed in NH, residual cough and wheezing
Case Presentation (cont.)

PE  Gen – Heavilyset, chronically ill
VS – BP: 108/68  P: 110  R: 16  T: 97.6
Lungs – Decreased air exchange
Heart – Irregularly irregular tachycardia
Ext – 1+ edema, chronic venous stasis
Neuro – A and O x3, left arm and leg hemiparesis
Case Presentation (cont.)

Diagnostic Studies:
- ECG: A fib with RVR
- CBC: WBC 12.9, Hb 11.8
- BMP: Glucose 215
- BNP: 675
- Troponin: 1.6
- UA: RBC’s TNTC; WBCs > 200 hpf
- CXR: Right base infiltrate, chronic changes
- CT Head: Microvascular ischemia, no acute hemorrhage
Problem List:

1. Stroke
2. A. Fib
3. UTI
4. Hematuria
5. Non STEMI
6. Heart Failure
7. Resolving Pneumonia
8. Hypertension
9. Diabetes Mellitus
10. Stable CAD
11. Ischemic Cardiomyopathy
12. HLP
13. Generalized OA
Pay for Performance – A New Era

The Past – Fee for Service
• Payment for \textit{quantity} of services

The Future – Pay for Performance
• Payment for \textit{quality} of care and accountability for cost of care
CMS Influence:

- **Mission:** “CMS is a constructive force and trustworthy partner for the continual improvement of health and healthcare for all Americans.”

- Largest payer for healthcare in US:
  - 45 million beneficiaries

- Sets national agenda for healthcare payment and policy.
CMS Challenge: Unsustainable Cost

Net Medicare Spending, 2010-2024

Actual Net Outlays

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>$446</td>
<td>$480</td>
<td>$466</td>
<td>$492</td>
</tr>
</tbody>
</table>

Projected Net Outlays

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>$512</td>
<td>$524</td>
<td>$563</td>
<td>$570</td>
<td>$579</td>
<td>$641</td>
<td>$686</td>
<td>$736</td>
<td>$821</td>
<td>$839</td>
<td>$858</td>
</tr>
</tbody>
</table>

Share of Federal Outlays:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>12.9%</td>
<td>13.3%</td>
<td>13.2%</td>
<td>14.2%</td>
<td>14.5%</td>
<td>13.9%</td>
<td>14.0%</td>
<td>13.6%</td>
<td>13.2%</td>
<td>13.8%</td>
<td>14.0%</td>
<td>14.3%</td>
<td>15.0%</td>
<td>14.7%</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

Share of GDP:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>3.0%</td>
<td>3.1%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.1%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of Medicare spending minus income from premiums and other offsetting receipts.
CMS Challenge: Untrustworthy Quality

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint

Overall Health Care Quality in U.S. (Rand Study 2003)

IRS Phone-in Tax Advice

Airline baggage handling

U.S Airline flight fatalities/U.S. Industry Best of Class

Fair Reliability

High Reliability

∑ level (% Defects)

1 (69%)
2 (31%)
3 (7%)
4 (.6%)
5 (.002%)
6 (.00003%)

Defects per million

10,000
1,000
100
10
1
Relationship Between Quality of Care and Medicare Spending

States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.

Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001

Overall quality ranking

Annual Medicare spending per beneficiary (dollars)

Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every $1,000 increase in Medicare spending per beneficiary, a state’s quality ranking dropped by 10 positions. Adapted and republished with permission of Health Affairs from Baicker and Chandra, “Medicare spending, the physician workforce, and beneficiaries’ quality of care” (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.

Leatherman and McCarthy, Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005. The Commonwealth Fund
The Value Equation:

\[ \text{Value} = \frac{\text{Quality}}{\text{Cost}} \]
“Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systemically improve the quality of care, and may even prevent such actions.”

IOM, Crossing the Quality Chasm, p 193.
2010 - The Affordable Care Act
Federal Register

Monday,
August 28, 2006

Part IV

The President

Executive Order 13410—Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs
Notice of August 24, 2006—Intention To Enter Into a Free Trade Agreement With Colombia
Executive Order 13410:

Directs Federal Agencies to:

1. Encourage adoption of health information technology standards for interoperability
2. Increase transparency in healthcare quality measurements
3. Increase transparency in healthcare pricing information
4. Promote quality and efficiency of care, which may include pay for performance
CMS Quality Agenda:

Transform Medicare from a **passive payer** to an **active purchaser** of higher quality, more efficient health care

Value-Based Purchasing
(payment based on quality)

Tools and initiatives for promoting better **quality**, while avoiding unnecessary **costs**

**Triple Aim**: Better Care, Better Health, Lower Cost
Triple Aim

Better health

Better care    Lower cost
The ABC’s of Medicare

**Part A** covers inpatient hospital stays, skilled nursing facilities, hospice care and home health care.

**Part B** covers doctors' services, outpatient care, medical supplies and preventive services.

**Part C** is the Medicare Advantage Plans

**Part D** covers pharmacy benefits
The ABC’s of Medicare

HOSPITAL (PART A)
- FICA
- UB04
- Inpatient Prospective Payment System
- MS-DRG’s
- Hospital Compare Web site
- $200 Billion Annual Spending

PHYSICIAN (PART B)
- Premium based
- Form 1500
- Physician Fee Schedule
- RBRVS
- Physician Compare Web site
- $110 Billion Annual Spending
# Medicare P4P Programs

<table>
<thead>
<tr>
<th>HOSPITAL (PART A)</th>
<th>PHYSICIAN (PART B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HOSPITAL VALUE-BASED PURCHASING PROGRAM</td>
<td>1. PHYSICIAN QUALITY REPORTING SYSTEM</td>
</tr>
<tr>
<td>2. READMISSIONS REDUCTION PROGRAM</td>
<td>2. PHYSICIAN VALUE BASED MODIFIER</td>
</tr>
<tr>
<td>3. HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM</td>
<td></td>
</tr>
</tbody>
</table>
HVB BP Program 2017 Measures

Clinical Care Measures

- Process Measures
  1. AMI-7 Fibrinolytics
  2. IMM-2 Influenza Immunization
  3. PCI-01 Elective Delivery Before 39 Weeks

- Outcome Measures
  1. AMI 30-Day Mortality
  2. HF 30Day Mortality
  3. PN 30-Day Mortality

Efficiency Measure

  1. MSPB-1 Spending per Beneficiary

Domain Weights

- Clinical Care: 30%
- Efficiency: 25%
- Safety: 20%
- Patient Experience of Care: 25%

Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Staff Responsiveness
4. Pain Management
5. Medication Communication
6. Cleanliness & Quietness
7. DC Info
8. Overall Rating

Safety Measures

1. AHRQ PSI-90 Composite
2. CLABSI
3. CAUTI
4. Surgical Site Infection: Colon & Hysterectomy
5. C. diff
6. MRSA
HVBP Performance Model Overview

- Hospitals submit data during **Baseline** and **Performance** periods
- Each measure has a **Threshold** and **Benchmark**
- CMS determines performance score of 0 to 10 points based on **Improvement** or **Achievement** for each measure

**Total Performance Score** - weighted combination of domain scores:
- 30% based on Clinical Care
- 25% based on Experience of Care
- 25% based on Efficiency
- 20% based on Safety
HVBP Incentive Payments

- Not all hospitals will earn the full VBP incentive payment
- Budget neutral - funded by reduction to base operating DRG payments
- Incentive payments as discharge add on
- Withhold applies to all DRGs, not just clinical areas measured
## HVBP Base Operating DRG Reduction

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>HVBP Medicare Revenue Withhold</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>1.25%</td>
</tr>
<tr>
<td>2015</td>
<td>1.5%</td>
</tr>
<tr>
<td>2016</td>
<td>1.75%</td>
</tr>
<tr>
<td>2017</td>
<td>2%</td>
</tr>
</tbody>
</table>
### General Information

- Hospital type: Acute Care Hospitals
- Provides emergency services: Yes
- Participates in: Stroke Care Registry
- Able to receive lab results electronically: Yes
- Able to track patients' lab results, tests, and referrals electronically between visits: Yes
- Uses a safe surgery checklist: Yes

### ST TAMMANY PARISH HOSPITAL

1202 S TYLER STREET
COVINGTON, LA 70433
(985) 898-4000

Add to my Favorites
Map and Directions

---

In the tables, you can hover over the footnote number to see the footnote text. View more footnote details.
Medicare P4P Programs

<table>
<thead>
<tr>
<th>HOSPITAL (PART A)</th>
<th>PHYSICIAN (PART B)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> HOSPITAL VALUE-BASED PURCHASING PROGRAM</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> READMISSIONS REDUCTION PROGRAM</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM</td>
<td></td>
</tr>
<tr>
<td><strong>1.</strong> PHYSICIAN QUALITY REPORTING SYSTEM</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> PHYSICIAN VALUE BASED MODIFIER</td>
<td></td>
</tr>
</tbody>
</table>
“Rates of unplanned readmission show whether a hospital is doing its best to prevent complications, provide clear discharge instructions to patients, and help patients make a smooth transition to their home or another setting such as a nursing home.”

Readmission Reduction Program

- Based on 30-day readmission rates for MI, HF, pneumonia, COPD and total hip/knee replacements
- “Any other conditions the Secretary chooses” will be added
- If readmit rate > Medicare expected, hospital payment adjusted:
  - 2013: 1% reduction in base DRG payments
  - 2014: 2% reduction in base DRG payments
  - 2015: 3% reduction in base DRG payments
- Structure such that up to 50% hospitals will always have penalty
Excess Readmission Ratio =
Risk Adjusted Actual Readmissions/
Risk Adjusted Expected Readmissions

**Numerator: Adjusted Actual Readmissions**

**Step 1:**
Calculate each patient’s predicted probability of readmission = \( \frac{1}{1 + e^{Z_a}} \)

\( Z_a = \text{hospital-specific effect} + X\beta \)

\( \text{intercept + risk-adjustment coefficients} \)

**Step 2:**
To get the numerator result, add all patients’ predicted probabilities of readmission

**Denominator: Expected Readmissions**

**Step 1:**
Calculate each patient’s expected probability of readmission = \( \frac{1}{1 + e^{Z_a}} \)

\( Z_a = X\beta \)

\( \text{intercept + risk-adjustment coefficients} \)

**Step 2:**
To get the denominator result, add all patients’ expected probabilities of readmission
Public Reporting of Readmissions

Rate of readmission after discharge from hospital (hospital-wide)

Why is this important?

Hide Graph

ST TAMMANY PARISH HOSPITAL

Lower Percentages Are Better

0% 5% 10% 15% 20% 25% 30% 35%

15.7%

16%

Number of included patients: 2271

U.S. National Rate of all cause hospital-wide readmission = 16.0%
Medicare P4P Programs

<table>
<thead>
<tr>
<th>HOSPITAL (PART A)</th>
<th>PHYSICIAN (PART B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>HOSPITAL VALUE-BASED PURCHASING PROGRAM</strong></td>
<td>1. <strong>PHYSICIAN QUALITY REPORTING SYSTEM</strong></td>
</tr>
<tr>
<td>2. <strong>READMISSIONS REDUCTION PROGRAM</strong></td>
<td>2. <strong>PHYSICIAN VALUE BASED MODIFIER</strong></td>
</tr>
<tr>
<td>3. <strong>HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM</strong></td>
<td></td>
</tr>
</tbody>
</table>
The Hospital Acquired Condition Problem

- HAC’s: 17 to 29 Billion of Medicare spending annually
- HAC’s selected by CMS:
  - High cost, high volume or both
  - Trigger higher payment as a secondary diagnoses (CC or MCC)
  - “Reasonably preventable” through the application of evidence-based guidelines
HAC 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
Hospital Acquired Condition Reduction Program

- Began October 1, FY2015
- Applies to one quarter of hospitals with lowest performance
- Payment adjustment: 1% reduction of inpatient hospital payments
- HAC Reduction Program in addition to HAC non-payment
- HAC Reduction Program adjustments applied after HVBP and Readmission penalties
Medicare P4P Programs

HOSPITAL (PART A)
1. HOSPITAL VALUE-BASED PURCHASING PROGRAM
2. READMISSIONS REDUCTION PROGRAM
3. HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM

PHYSICIAN (PART B)
1. PHYSICIAN QUALITY REPORTING SYSTEM
2. PHYSICIAN VALUE BASED MODIFIER
The Value Equation:

\[ \text{Value} = \frac{\text{Quality}}{\text{Cost}} \]
Physician Performance is All Over the Map

Adapted from Regence Blue Shield

© 2006 A. Milstein MD
Physician Branding

- High Quality, Low Cost
- High Quality, High Cost
- Low Quality, Low Cost
- Low Quality, High Cost
Physician Quality Reporting System

- Formerly PQRI
- Voluntary Program (at first)
- Pay for Reporting (at first)

Statutory Authority:
- 2006 Tax Relief and Health Care Act
Internal Medicine
Top 5 PQRS Performance Measures

Measure #:
1. Diabetes Mellitus: HbA1c Poor Control
2. Diabetes Mellitus: LDL Control
3. Diabetes Mellitus: HBP Control
111. Preventive Care and Screening: Pneumococcal Vaccine
124. Health Information Technology: Adoption of EHR
PQRS Reporting: Choose 9 Measures*

Reporting Options:
1. Medicare Part B Claims
2. CMS Qualified PQRS Registry
3. Electronic Health Record Reporting
   • CEHRT
4. Group Practice Reporting Options (GPRO)
5. Qualified Clinical Data Registry

*Less than 9 measures subject to Measure-Applicability Validation (MAV)
PQRS Incentive Payment

Percentage of Total Allowable Medicare Charges:

- 2010 - 2% Bonus
- 2011 - 1% Bonus
- 2012 - 0.5% Bonus
- 2013 - 0.5% Bonus
- 2014 - 0.5% Bonus
- 2015 - negative 1.5% payment adjustment (non participating physicians will receive only 98.5% of their Total Allowable Medicare Charges for the year)
- 2016 - negative 2% payment adjustment
## PQRS Participation 2012

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Eligible Professionals</th>
<th>Eligible Professionals who Participated</th>
<th>Percent of Eligible Professionals who Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>52,617</td>
<td>33,880</td>
<td>64.4%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>42,342</td>
<td>24,317</td>
<td>57.4%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>87,971</td>
<td>18,745</td>
<td>21.3%</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>45,554</td>
<td>18,669</td>
<td>41.0%</td>
</tr>
<tr>
<td>Radiologist</td>
<td>35,443</td>
<td>18,333</td>
<td>51.7%</td>
</tr>
<tr>
<td><strong>Internal Medicine</strong></td>
<td>86,014</td>
<td>17,477</td>
<td>20.3%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>51,460</td>
<td>12,953</td>
<td>25.2%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>61,076</td>
<td>10,136</td>
<td>16.6%</td>
</tr>
<tr>
<td>Optometry</td>
<td>33,252</td>
<td>9,969</td>
<td>30.0%</td>
</tr>
<tr>
<td>Physical/Occupational Therapy</td>
<td>46,597</td>
<td>9,246</td>
<td>19.8%</td>
</tr>
</tbody>
</table>
Public Reporting on physiciancompare.gov
Value-Based Payment Modifier: What Is It?

1. Physician payment based on quality of care and cost of care.
2. Budget Neutral: payment will increase for some but decrease for others - aggregate Medicare spending for physician services will not change.
3. VM applies to:
   - Groups of 2 to 9 and Solo Practitioners
   - Groups with 10 to 99 Physicians
   - Groups with 100 or more Physicians
4. Group assignment based on Tax ID Number (TIN)
# 2013 Medicare Fee-for-Service Quality and Resource Use Report

**St. Tammany Parish Hospital**

Last Four Digits of Your Taxpayer Identification Number (TIN): 8620

## About This Report From Medicare

### WHAT

This Quality and Resource Use Report shows how you performed in 2013 on the quality and cost measures used to calculate value-based performance. Because you will not be subject to the value-based payment modifier in 2015, the report is for informational purposes only and will not affect your Medicare Physician Fee Schedule reimbursements in 2015. This report also includes performance information on new measures that will be used in the value-based payment modifier for 2016.

### WHO

The Centers for Medicare & Medicaid Services (CMS) is phasing in a value-based payment modifier under the Medicare Physician Fee Schedule in 2015 and 2016.

- In 2015, physician groups of 100 or more eligible professionals that submit claims to Medicare under a single Taxpayer Identification Number (TIN) will be subject to the payment modifier, based on their performance in calendar year 2013.

- In both 2015 and 2016, the value-based payment modifier will not apply to those physician groups and solo practitioners participating in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative.

- Medicare records indicate that the value-based payment modifier will not apply to you in 2015 because either no physicians or fewer than 100 eligible professionals billed to your TIN in 2013.

### HOW

In 2015, the value-based payment modifier for physicians in groups of 100 or more eligible professionals will be based on participation in the Physician Quality Reporting System (PQRS) in 2013.
VM Quality Measures

- PQRS Measures
- Acute Prevention Quality Indicator Composite
  - Bacterial Pneumonia
  - Urinary Tract Infections
  - Dehydration
- Chronic Prevention Quality Indicator Composite
  - COPD
  - Heart Failure
  - Diabetes
- All-Cause Hospital Readmission Measure
VM: Cost Measures

- Total Per Capita Cost Measure
- Per Capita Cost Measure for Chronic Conditions
  - Diabetes
  - Heart failure
  - CAD
  - COPD
- Medicare Spending Per Beneficiary Measure
# Value-based Modifier Payment Adjustment

| Value-based Payment Modifier | All physicians in groups with 2+ EPs and physicians who are solo practitioners | **Mandatory Quality-Tiering for PQRS reporters-**  
Groups with 2-9 EPs and solo practitioners: Upward or neutral VM adjustment only based on quality-tiering (+0.0% to +2.0x of MPFS)  
Groups with 10+ EPs: Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)  
Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.  
Non-PQRS reporters-  
Groups with 2-9 EPs and solo practitioners: automatic -2.0% of MPFS downward adjustment  
Groups with 10+ EPs: Automatic -4.0% of MPFS downward adjustment |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem List:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A Fib</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. UTI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hematuria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Non STEMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Resolving Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Diabetes Mellitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Stable CAD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ischemic Cardiomyopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. HLP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Generalized OA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coding Summary
Print Date: 1/8/2014 2:12:54PM

Patient Name: [Redacted]  
Date of Birth: 10/17/1936  
Age at Admit: 83 years  
Admit Date/Time: 01/07/2014 0000  
Attend Phys: 0000654 Torcsen, Patrick J 
Patient Type: I INPATIENT  
Det Pt Type: Z EMERGENCY ROOM  
Disch Service: MED MEDICAL  
Admit Dx: 294.20 Demen NOS w/o behv distrb  
DRG Description MDC Weight  
064 INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC 001 1.7417  
Seq POA CC Diagnosis Description  
1 Y * 434.91 Unspecified cerebral artery occlusion with cerebral infarction  
2 Y % 486 Pneumonia, organism unspecified  
3 Y # 599.0 Urinary tract infection, site not specified  
4 Y 427.31 Atrial fibrillation  
5 Y 599.70 Hematuria, unspecified  
6 Y 401.9 Essential hypertension, unspecified benign or malignant  
7 Y 250.00 Diabetes mellitus without complication, type II or unspecified type, not stated as uncontrolled  
8 Y 414.01 Coronary atherosclerosis of native coronary vessel  
9 Y 414.8 Specified form of chronic ischemic heart disease  
10 Y 272.4 Unspecified hyperlipidemia  
11 Y 715.00 Generalized osteoarthritis, site unspecified  
GMLOS ALOS Expect Reimb Coder ID Coded Date Final Date  
4.70 6.30 SBONO 01/08/2014
**Hospital P4P Bottom Line:**

DRG 064: $1.7417 \times 5,906 = \$10,286.48$

P4P Incentive:

- HVBP Program: 2% = $205.73$
- Readmissions Reduction: 3% = $308.59$
- HAC Reduction Program: 1% = $102.86$

Total P4P Incentive = $617.84$

Net Hospital Reimbursement = $9,668.64$
**Hospital** P4P Bottom Line:

**Medicare Part A Revenue:** $50,000,000

**P4P Incentive:**

- HVBP (MI, HF, HCAHPS): 2% = $1,000,000
- Readmissions Reduction: 3% = $1,500,000
- HAC Reduction Program: 1% = $500,000

**Total P4P Incentive at Risk:** $3,000,000

*250 bed community hospital*
<table>
<thead>
<tr>
<th>Date</th>
<th>Place of Service</th>
<th>Procedure</th>
<th>Modifier</th>
<th>Diagnosis Pointer</th>
<th>Charges</th>
<th>Days</th>
<th>Amount Paid</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 14 01</td>
<td>99223</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td>188.50</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01 08 01</td>
<td>99233</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td>96.45</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01 09 01</td>
<td>99232</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td>66.92</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01 10 01</td>
<td>99232</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td>66.92</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01 11 01</td>
<td>99239</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td>99.35</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Charge:** $518.14

**Torscson, Patrick**

12 30 2013

ST TAMMANY PARISH HOSPITAL
1202 S TYLER ST
COVINGTON LA 704332330

NUCC Instruction Manual available at: www.nucc.org
Physician P4P Bottom Line:

Total Reimbursement 5-day LOS: $518.14

P4P Incentive:
  PQRS: 2% = $10.37
  VM: 4% = $20.73

Total P4P Incentive = $31.10

Net Physician Reimbursement = $487.04
Physician P4P Bottom Line:

Medicare Part B Revenue: $101,063.20

P4P Incentive:
  PQRS: 2% = $2,021.26
  VM: 4% = $2,021.26

Total P4P Incentive at Risk: $6,063.78
P4P Summary/Conclusions:

- Healthcare payment system is changing.
- Medicare P4P has arrived:
  - Hospital: 6% Part A revenue at risk through HVBP, RRP and HACRP.
  - Physician: 6% Part B revenue at risk through PQRS and VM.
- Commercial insurance P4P programs are following.
P4P Summary/Conclusions:

- P4P demands new skills and competencies:
  - Understanding quality data and attribution models
  - Implementing PI methods
  - Advocacy and public policy
- End game?
“The Department of Health and Human Services aims to tie 30% of Medicare fee-for-service payments to alternative payment models and 85% to quality or value by 2016. The plan calls for increasing these proportions to 50% and 90%, respectively, by 2018”
Payment System Changing from Volume (Curve 1) to Value (Curve 2)

Curve #1: FEE-FOR-SERVICE
- All About Volume
- Reinforces Work In Silos
- Little Incentive For “Real” Integration

Curve #2: VALUE-BASED PAYMENT MODELS
- Pay for Performance
- Shared Savings
- Bundled Payments
- Fixed Payments

Shifting Risk from Payers to Providers
“Ultimately, however, what a physician does or does not do depends on the Hippocratic Oath, ethics, and morals.”

Robert H. Brook, MD, ScD
Physician Compensation, Cost and Quality
JAMA. 2010;304(7): 795-796.
CARTOON

A man stands in a store front with a sign above him that reads "CARDS." On the right side, there is a display labeled "GET WELL," and on the left, another display labeled "CONGRATULATIONS." Between the displays, a sign reads "GOOD LUCK WITH THE AMERICAN HEALTH-CARE SYSTEM." The man is looking at the displays, seemingly confused.
Pay for Performance for the Hospital and Physician

Comments/Questions?