MEDICARE’S CALL TO ACTION: Moving from Competition to Collaboration

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Learning Objectives:

- Provide information about the new QIO structure and the Centers for Medicare & Medicaid Services (CMS) defined areas of focus.
- Share the success of the No Place Like Home Campaign in Arizona.
- Identify populations of focus that the Centers for Medicare & Medicaid Services (CMS) has identified specific to readmissions.

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Medicare’s Call to Action: Moving from Competition to Collaboration

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Presentation Objectives

1. Provide information about the new Quality Improvement Organization (QIO) structure and the Centers for Medicare & Medicaid Services (CMS) areas of focus.

2. Share the success of the No Place Like Home Campaign in Arizona.

3. Identify populations of focus that CMS has identified specific to readmissions.
National Success in Reducing Readmissions in Communities

Nearly $1 billion
In cost savings from combined QIO Programs

- Over 14,000,000 Medicare beneficiaries live in the communities served by the QIO Program
- The Program collectively saved over 27,000 people from being readmitted to the hospital and over 95,000 from being admitted to the hospital

Press Release: July 18, 2014
CMS Launches Next Phase of New Quality Improvement Program

HSAG: Your Partner in Healthcare Quality

- HSAG is Arizona’s Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO).
- QIN-QIOs in every state and territory are united in a network administered by CMS.
- The QIN-QIO program is the largest federal program dedicated to improving health quality at the community level.
New National QIN-QIO Structure

Medical Case Review Structural Changes

• CMS separated medical case review from quality improvement work creating two separate structures:
  - Quality improvement performed by Quality Innovation Network QIOs (QIN-QIOs)
  - Medical case review performed by Beneficiary Family Centered Care QIOs (BFCC-QIOs)

QIN-QIO Framework
Healthy People, Healthy Communities

- Improve cardiac health and reduce cardiac healthcare disparities.
  - Implement evidence-based practices to improve cardiovascular health.
  - Support the Million Hearts® initiative.
  - Promote the use of Aspirin, Blood pressure control, Cholesterol management, and Smoking assessment and cessation (ABCS).
  - Work with racial and ethnic minority beneficiaries/dual-eligibles, and providers to improve ABCS.

Healthy People, Healthy Communities (cont.)

  - Improve HbA1c, lipids, blood pressure, and weight control.
  - Decrease number of beneficiaries requiring lower-extremity amputations.
  - Provide and facilitate diabetes self-management education training classes.
  - Increase adherence for appropriate use of utilization measures (HbA1c, lipids, eye exams).

Healthy People, Healthy Communities (cont.)

- Improve prevention coordination through Meaningful Use of Health Information Technology (HIT).
  - Coordinate with Regional Extension Centers to disseminate successful interventions.
  - Foster HIT adoption to improve beneficiary care.
  - Increase screening and delivery of preventive services with the use of electronic health record technology.
  - Improve access to care and coordination by supporting beneficiary and family engagement.
Better Healthcare for Communities

- Reduce healthcare-associated infections (HAIs) in hospitals.
  - Prevent occurrence of HAIs using data-driven, evidence-based practices.
  - Use results to initiate quality improvement initiatives in intensive care and non-intensive care units.
  - Develop and provide recommendations for improvement strategies.
  - Use HAI data and outcomes to inform results and policy at the national level.

Better Healthcare for Communities (cont.)

- Reduce healthcare-acquired conditions in nursing homes.
  - Support National Nursing Home Quality Care Collaborative initiatives.
  - Achieve a score of 6.0 or lower on the Nursing Home Quality Composite Measure.
  - Improve rates of mobility among long-stay nursing home residents.
  - Reduce use of unnecessary antipsychotic medications in dementia residents.

Better Healthcare for Communities (cont.)

- Coordination of care
  - Reduce hospital admission and readmission rates by 20 percent by 2019.
  - Increase community tenure (less time in facilities).
  - Reduce prevalence of adverse drug events (ADEs) that contribute to patient harm as a result of the care-transition process.
  - Convene community providers to collaborate on strategies for improvement in coordination of care.
Better Care at Lower Cost

• Make care more affordable.
  – Quality improvement through the Physician Value-Based Modifier and the Physician Feedback Reporting Program
  – Projects that advance efforts for better care at a lower cost

Better Care at Lower Cost (cont.)

No Place Like Home Campaign

While great strides have been accomplished...

further progress on behalf of our patients is essential.
2012: The Affordable Care Act Introduces Hospital Readmission Penalties

- **FY 2013** (due by October 1, 2012)
  - HRRP penalty rate set in Q4 of 2012
  - HRRP penalty calculation published in August 2012
  - FY 2013 penalties (4% of federal Medicare payments)

- **FY 2014** (due by July 30, 2013)
  - HRRP penalty rate set in Q4 of 2013
  - HRRP penalty calculation published in August 2013
  - FY 2014 penalties (5% of federal Medicare payments)

- **FY 2015** (due by July 30, 2014)
  - HRRP penalty rate set in Q4 of 2014
  - HRRP penalty calculation published in August 2014
  - FY 2015 penalties (4% of federal Medicare payments)

*Conditions included for penalty calculation: AMI=acute myocardial infarction, CHF=congestive heart failure, PNE=pneumonia, COPD=chronic obstructive pulmonary disease, TKA=total knee arthroplasty, and THA=total hip arthroplasty.

Hospital Readmission Recap

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Hospitals Penalized</th>
<th>Hospitals Receiving Max Penalty</th>
<th>National Average Fine</th>
<th>$ million Recouped by CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2,217</td>
<td>307 at 1%</td>
<td>0.42</td>
<td>$280 million</td>
</tr>
<tr>
<td>2014</td>
<td>2,225</td>
<td>154 at 1%</td>
<td>0.38</td>
<td>$227 million</td>
</tr>
<tr>
<td>2015</td>
<td>2,610</td>
<td>18 at 2%</td>
<td>0.63</td>
<td>$428 million</td>
</tr>
</tbody>
</table>

Hospital Readmissions National Trend

- "Overall readmission rates in 2012 were lower than they had been during the previous five years."
- Medicare & Medicaid Research Review, 2013, Volume 3, Number 2
Phase I goals (January 1, 2012–June 30, 2013):
1. Prevent 4,000 readmissions within 30 days of hospital discharge by June 30, 2013.
2. Reduce the overall readmission rate for Medicare beneficiaries by 20 percent (based on claims data from Medicare 2010).
3. Decrease healthcare expenditures related to readmissions.

Phase I goals results:
• Arizona had the highest relative improvement rate (RIR) for readmissions and admissions in the country.
  – More than double the national RIR.
• Exceeded our goals due to increase in population.
• From 2010 to 2013, Arizona has seen a relative reduction in readmissions for Medicare fee-for-service patients of 19 percent, translating to more than 5,972 averted readmissions.

Arizona Impact:
How Did Arizona Hospitals Fare?
Causes for Readmissions

What are the populations of focus that CMS identified specific to readmissions?

ADEs and Readmissions

ADEs prolong hospital length of stay by approximately 1.7 to 4.6 days

Cost up to $5.6 million per hospital

Identified as the most common causes of post-discharge complications

Occurring within three weeks of hospital discharge

Depending on the type of ADE, overall costs range from $677 to more than $9,000 per patient

Patient Implementation of Prescribed Medications

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One Approach: Use the Pharmacist

- Randomized trial of 178 patients discharged from general medicine service
- Pharmacist counseling reduced preventable ADEs from 11 percent in the control group to 1 percent in the intervention group


Populations of Focus: Diabetes

Nationally:
25.8 million people (8.6% of adults) diagnosed with diabetes in the United States

It is estimated that:
- 20% of adults are pre-diabetic


2007 Diabetic Costs by Area

Average Hospital Inpatient Charges, Type 2 Diabetes

Have You Ever Been Told by a Doctor That You Have Diabetes?

Source: 2011 Arizona Behavioral Risk Factor Surveillance Survey

Admissions from Nursing Homes

Medicare spent almost $3 billion on nursing home resident hospitalizations with septicemia.
That’s more than the next three most expensive conditions combined!

Total Septicemia cost: $2,963,329,522

Nursing Homes and Readmissions

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