

# Medicare Hospital Inpatient Value Based Purchasing Program

Presented by  
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**Deloitte.**

## Agenda

- The Case for Change and Value Based Purchasing
- Preparing for Reimbursement Change
- Emerging Leading Practices
- Conclusion and Questions



# The Case for Change and Value Based Purchasing

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## Health Care Reform

- Why?
- Where are we?
- What is ahead?



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## Health Care Reform

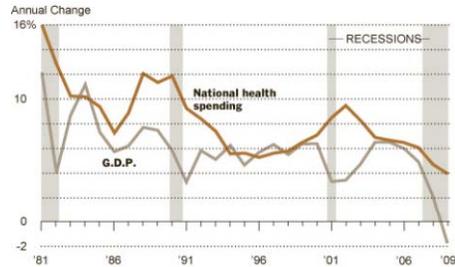
Health costs up 4% in 2009 to 17.6% of GDP

- Overall health expenditures increased 4% to \$2.49 trillion, or \$8,086 per capita for 2009
- Expenditures for 2009 represented a 1% increase in economic significance: from 16.6% to 17.6% of overall GDP
- Federal spending for Medicaid increased 22% in 2009 vs. 2008 (while state spending decreased 10%)

### Rate of Health Care Spending

National spending on health care increased only 4 percent from 2008 to 2009, the smallest annual increase in decades.

PERCENT CHANGE IN NATIONAL HEALTH EXPENDITURES AND G.D.P.



Sources: Centers for Medicare & Medicaid Services; Bureau of Economic Analysis; National Bureau of Economic Research THE NEW YORK TIMES



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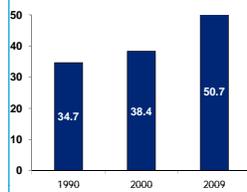
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## Health Care Reform

### Access

The number of Americans without health insurance coverage is high and climbing higher

The Uninsured in America 1990-2009 (in millions)



Source: data from U.S. Census Bureau

### Cost

The US spends significantly more per capita on health care than other industrialized nations

Health Care Spending Per Capita, 2007 Comparison of 10 OECD Countries



Source: Organisation for Economic Co-operation and Development, OECD Health Data 2009

### Quality

Despite higher US spending, our nation lags behind benchmark countries in measures of health care outcomes

Life Expectancy at Birth, 2004 Comparison of 10 OECD Countries

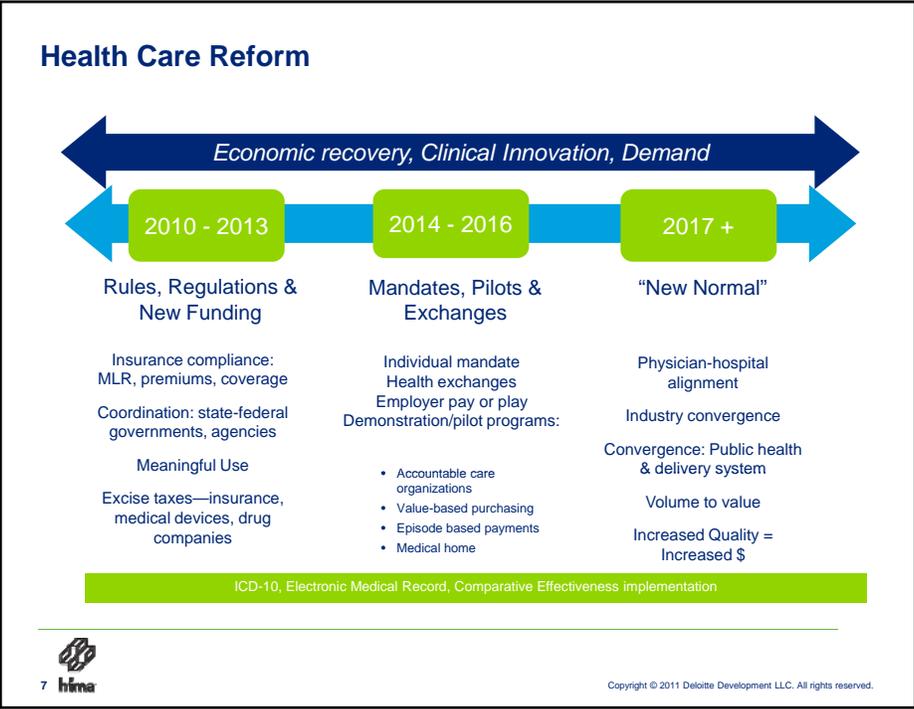
	OECD Average	United States	US Ranking (out of 15 countries)
Health Care Expenditure % of GDP*	8.9%	16.0%	15th
Average Life Expectancy at Birth	79.1	78.1	14th
Public Financing % of Health Care	73.0%	45.4%	14th
Prevalence of Diabetes in Adults (aged 20-79)*	6.3%	10.3%	14th
Prevalence of Obesity		34.0%	14th
Rate of Caesarean Deliveries*	25%	31%	12th
# of Asthma Hospital Admission Rates per 100,000 (aged 15+)*	51	120	15th
# of Diabetes Complications Admission Rates per 100,000 (aged 15+)*	21	57	15th

Source: OECD Health Data 2006



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### Paying for Value

CMS' VBP Program is reflective of the shift in payment from transactional to outcome based

Program	CMS and Medicaid	Commercial
Pay for Performance	VBP -2% to +2%	Incentive basis "tiering" requirement for rate increased
HAC and Never Events	1% Reimbursement at Risk	Numerous programs by payer
Re-admissions	1% Reimbursement at Risk due to excessive re-admissions for pneumonia, heart failure, and heart attack	Numerous programs by payer
Global Prepayment	ACO's	Integrated payer/provider (Kaiser)

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## Health Care Reform

The “five big bets” in PPACA

- **Individual mandate:** Will the uninsured and newly eligible for Medicaid enroll? Will the insured increase by 32 million as targeted? Is risk spread appropriately?
- **Employer exit:** Will employers drop health benefits after 2016 to facilitate direct consumer engagement and there by reduce operating costs? Will their employees purchase through the exchanges, or go without? Is PPACA the road to employers exiting health insurance?
- **State capabilities:** Will states be able to manage their expansion new responsibilities and obligations? Can states manage population-based health (Medicaid, CHIP, workers comp) & insurance risk effectively?
- **Delivery system costs:** Will delivery system reforms-accountable care organizations, value-based purchasing, medical homes, bundled payments, comparative effectiveness – reduce costs over time?
- **Quality:** Are Americans ready for limits based on cost and comparative effectiveness?



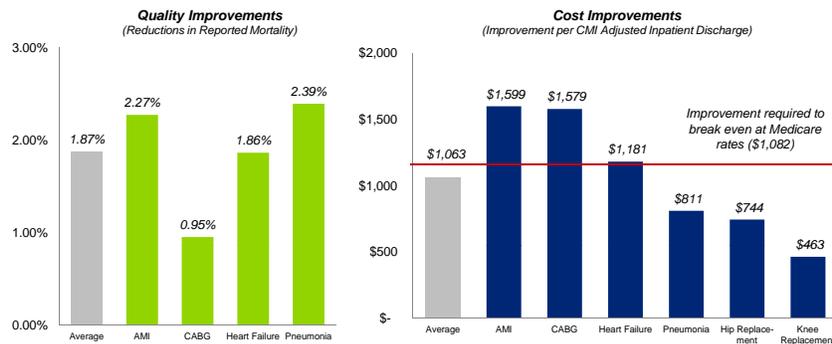
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## The Value Proposition

Gains observed in Premier’s Hospital Quality Incentive Demonstration (HQID) project show the potential for providers who are able to push the “value frontier.”

### Reported Quality and Cost Improvements



If all hospitals in the nation were to achieve this improvement, the estimated cost savings would be greater than **\$4.5 billion annually** with estimated **70,000 lives saved per year**.



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## CMS Will Begin Paying for Value

On April 29, 2011, CMS published the final regulations establishing the value-based purchasing (VBP) program for acute care hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), as required by PPACA Section 2013.

	FY2013	FY2014
<b>Measures</b>	2 Domains: <ul style="list-style-type: none"> <li>Process of Care (12 measures) – 70% <i>weighted</i></li> <li>Patient Experience (8 HCAHPS dimensions) – 30% <i>weighted</i></li> </ul>	3 Domains (weights TBD): <ul style="list-style-type: none"> <li>Process of Care</li> <li>Patient Experience</li> <li>Outcomes                             <ul style="list-style-type: none"> <li>3 mortality</li> <li>8 Hospital Acquired Conditions</li> <li>2 AHRQ Patient Safety Composites</li> </ul> </li> </ul>
<b>Baseline Time Period</b>	July 1, 2009 to March 31, 2010*	<ul style="list-style-type: none"> <li>Process of Care and Patient Experience: full year, TBD</li> <li>Outcomes: full year, TBD</li> </ul>
<b>Performance Time Period</b>	July 1, 2011 to March 31, 2012*	<ul style="list-style-type: none"> <li>Process of Care and Patient Experience: full year TBD</li> <li>Outcomes:                             <ul style="list-style-type: none"> <li>Mortality: July 1, 2011 to June 30, 2012</li> <li>HACs &amp; AHRQ Measures: begins March 2012</li> </ul> </li> </ul>

Total hospital VBP payments across all hospitals will be funded through a reduction in base operating diagnostic-related group (DRG) payments for each discharge, beginning at 1% in FY2013 and reaching 2% in FY2017.

The overarching goal of VBP is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries

Plan to initially use ¼ of a year because CMS needs time to calculate total performance scores, value-based incentive payments, notify hospitals regarding their payment adjustments, and implement the payment adjustments.

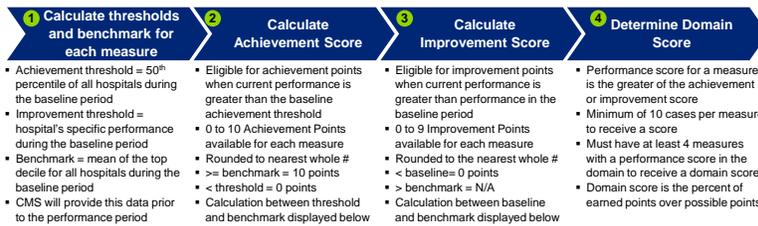


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## Methodology: Scoring Process of Care & Outcomes

*Process of Care and Outcomes* domains receive performance scores based on the greater of achievement and improvement scores, which encourages lower performing hospitals to continue improvement efforts.



**1 Sample Thresholds and Benchmark**

Achievement Threshold	0.47
Improvement Threshold	0.21
Benchmark	0.87

**2 Sample Achievement Scores**

Baseline Achievement	0.47
Baseline Benchmark	0.87
Current Performance	0.70

**Calculation:**  
 $[ 9 * ((0.70 - 0.47) / (0.87 - 0.47))] + 0.5 = 5.675$

Rounded up to an Achievement Score of 6

**3 Sample Improvement Scores**

Baseline Performance (i.e. Improvement Threshold)	0.21
Baseline Benchmark	0.87
Current Performance	0.70

**Calculation:**  
 $[ 10 * ((0.70 - 0.21) / (0.87 - 0.21))] - 0.5 = 6.92$

Rounded up to an Achievement Score of 7

**4 Calculation:**  
 Domain score = (total earned points) / (total possible points) \* 100%

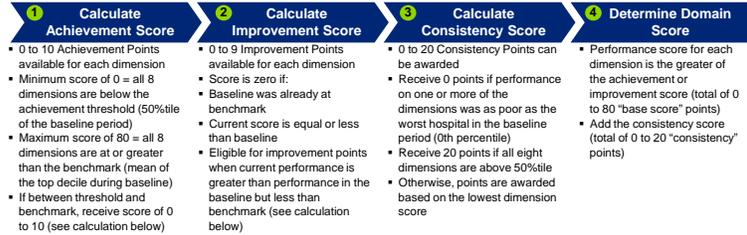


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## Methodology: Scoring Patient Experience

The **Patient Experience** domain also utilizes achievement and improvement scores but incorporates a consistency score as well to promote uniform focus across all HCAHPS dimensions.



**1 Sample Achievement Scores**

Achievement Threshold	0.79
Benchmark	0.89
Current Performance	0.82

**Calculation:**  
 $[9((0.82 - 0.79) / (0.89 - 0.79))] + 0.5 = 3.2$

*Rounded to nearest integer for an Achievement Score of 3*

**2 Sample Improvement Scores**

Baseline Score	0.77
Baseline Benchmark	0.89
Current Performance	0.82

**Calculation:**  
 $[10 * ((0.82 - 0.77) / (0.89 - 0.77))] - 0.5 = 3.67$

*Rounded up to an Improvement Score of 4*

**3 Calculation:**  
 $[20 * (\text{lowest dimension score} - 0.5)]$   
 Rounded to the nearest integer

*Lowest dimension score = (Hospital performance score - floor) / (Achievement Threshold - floor)*

*Floor = 0th percentile*

**4 Calculation:**  
 Patient Experience Domain Score = "Base Score" + "Consistency Score"



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## Incentive Payment Methodology

Four mathematical exchange function options were considered (straight line - linear; concave curve - cube root function; convex curve - cube function; and S shape - logistic function) when deciding the methodology for distributing VBP payments. Ultimately, the linear exchange function was proposed in the rule.

Payment Reduction to Base Operating DRG by Year		Slope	Breakeven VBP Performance Score
FY2013	1.0%	1.5	67%
FY2014	1.25%	1.6	63%
FY2015	1.5%	1.7	59%
FY2016	1.75%	1.8	56%
FY2017	2.0%	1.9	53%
		2.0	50%
		2.1	48%
		2.2	45%
		2.3	43%
		2.4	42%
		2.5	40%

### Key Takeaways

- Linear function provides all hospitals the same marginal incentive to continually improve
- Function's intercept is zero, meaning hospitals with scores of zero will not receive an incentive payment
- Payment for each hospital with a score above zero will be determined by the slope of the linear exchange function, which will be set to meet the budget neutrality (Hospital Incentive Payment = Slope \* Hospital Total Performance Score)
- Roughly half of hospitals will receive a net increase in payments and half will receive a net decrease in payments
- Among the 3,092 hospitals that will be participating in the Hospital VBP program, CMS used 2009 data to estimate that the incentive payments (i.e., the percentage of the base operating DRG withheld earned back) will range from 2.36% for the lowest-scoring hospital to 181.7% for the highest-scoring hospital
- Overall, the distributive impact of this rule is estimated at \$850 million for FY 2013 (reflected in 2010 dollars)
- The slope of the linear exchange function is determined by the highest VBP incentive payment divided by the highest VBP total performance score (if the best score in the CMS estimate were 100% then the slope would equal 1.817).



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## Timing and Communications

Hospitals must rapidly prepare for the VBP legislation as the performance period for Process of Care and Patient Experience measures included in the FY2013 program begins on July 1, 2011.

Timing	Communication
January 13, 2011	Publication of Proposed Rule
March 8, 2011	Last day to submit comments on Proposed Rule
April 29, 2011	Publication of the Final Rule
July 1, 2011 to March 31, 2012	Performance Period for FY2013 for Process of Care and Patient Experience Domains ( <i>Baseline Period for FY2013: July 1, 2009 to March 31, 2010</i> )
TBD	Performance Period for FY2014 for Outcomes Domain ( <i>Baseline Period: 12 months TBD</i> )
August 2, 2012 (60 days prior to start of FY2013)	Hospitals will be informed, through their QualityNet account, of the estimated amount of their value-based incentive payment adjustment for FY2013 discharges, derived from the most recently available data
October 1, 2012	1% reduction applies to discharges occurring on or after this date for the FY2013 VBP Program
November 1, 2012	Notification of the exact amount of the value-based incentive payment adjustment for FY 2013 discharges, including VBP performance measure score, condition-specific score, domain-specific score, and total performance score
December 1, 2012	Deadline to submit corrections related to performance measure scores, condition-specific scores, domain-specific scores and total performance scores
January 2013	Value-based incentive payment adjustment incorporated into claims processing system, and applied to all FY2013 discharges (including those that occurred beginning October 1, 2012)

The Secretary may choose measures that have been included on the Hospital Compare website for at least one year prior to the beginning of the performance period.



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## Process of Care Domain: Measures for FY2013

70% of a hospital's performance score will be based on 12 Process of Care measures. Each measure must have a minimum of 10 cases to be included and at least 4 measures must be reported to receive a domain score.

Category	Measure ID	Measure Description
Acute myocardial infarction	AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
	AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	HF-1	Discharge Instructions
Pneumonia	PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
	PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
Healthcare-associated infections	SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
	SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
	SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
	SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
Surgeries	SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
	SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
	SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery



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### Patient Experience Domain: Dimensions for FY2013

30% of a hospital's performance score will be based on 8 HCAHPS dimensions. A minimum of 100 HCAHPS surveys during performance period is required to be eligible for a performance score.

Dimension (Composite or stand-alone item)	Constituent HCAHPS survey items
1. Nurse communication (% "Always")	Nurse-Courtesy/Respect
	Nurse-Listen
	Nurse-Explain
2. Doctor communication (% "Always")	Doctor-Courtesy/Respect
	Doctor-Listen
	Doctor-Explain
3. Cleanliness and quietness (% "Always")	Cleanliness
	Quietness
4. Responsiveness of hospital staff (% "Always")	Bathroom Help
	Call Button
5. Pain management (% Always")	Pain Control
	Help with Pain
6. Communication about medications (% "Always")	New Medicine-Reason
	New Medicine-Side Effects
7. Discharge information (% "Yes")	Discharge-Help
	Discharge-Systems
8. Overall rating (% "9 or 10")	Overall Rating

The HCAHPS survey is administered to a random sample of adult patients across medical conditions between 48 hours and six weeks after discharge; the survey is not restricted to Medicare beneficiaries.

### The Fine Print: Additional VBP Details

- **Topped out measures** – when the overall 75<sup>th</sup> %tile and 90<sup>th</sup> %tile of a measure is statistically indistinguishable, it will be excluded because measuring would have no meaningful effect on a hospital's performance score
- **Future measures** – the Secretary must ensure that the selected measures include measures on six specified conditions or topics: Acute Myocardial Infarction (AMI); Heart Failure (HF); Pneumonia (PN); Surgeries, as measured by the Surgical Care Improvement Project (SCIP); Healthcare-Associated Infections (HAI); and, the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS)
- **Retiring measures** - a sub-regulatory process will also be proposed to retire Hospital VBP measures
- **Distinguishing providers** – payment adjustments to hospitals will be distinguished by provider number in hospital cost reports
- **Missing data during the baseline period** - these hospitals will still be included in the Hospital VBP program, but that they will be scored based only on achievement
- **On-going communication** - Secretary will periodically post on the Hospital Compare website aggregate information on the Hospital VBP program, including: (1) the number of hospitals receiving value-based incentive payments under the program as well as the range and total amount of such value-based incentive payments; and (2) the number of hospitals receiving less than the maximum value-based incentive payment available for the fiscal year involved and the range and amount of such payments

## An Increasing Impact of Quality on Reimbursement

Between 2013 and 2017, the amount of a Provider's Medicare Inpatient payments that will be at risk or available for bonus payments through the HAC and VBP programs will increase from 1.8% to 4.6%.

	FY2013	FY2014	FY2015	FY2016	FY2017
Hospital Acquired Conditions			1.0%	1.0%	1.0%
Value Based Purchasing (At Risk)	1.0%	1.25%	1.5%	1.75%	2.0%
Value Based Purchasing (Bonus)*	0.8%	1.0%	1.2%	1.4%	1.6%
<b>Range of Impact</b>	<b>1.8%</b>	<b>2.25%</b>	<b>3.7%</b>	<b>4.15%</b>	<b>4.6%</b>

\*1/13/11 Proposed Rule estimates that bonus payment max is approximately 180% (181.7%) based on sample data analyzed during the development of the rule.

A hospital, with \$50M in Annual Medicare Inpatient Payments has an estimated **\$8.25M** risk/opportunity in the 5 years between 2013 and 2017 from PPACA quality related reimbursement

	FY2013	FY2014	FY2015	FY2016	FY2017	5-year Total
Hospital Acquired Conditions			\$ .5M	\$ .5M	\$ .5M	<b>\$1.5M</b>
Value Based Purchasing (At Risk)	\$ .5M	\$ .625M	\$ .75M	\$ .875M	\$1.0M	<b>\$3.75M</b>
Value Based Purchasing (Bonus)*	\$ .4M	\$ .5M	\$ .6M	\$ .7M	\$ .8M	<b>\$3.0M</b>
<b>Range of Impact</b>	<b>\$ .9M</b>	<b>\$1.125M</b>	<b>\$1.85M</b>	<b>\$2.075M</b>	<b>\$2.3M</b>	<b>\$8.25M</b>



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## What Providers Should be Doing Now

- Know your score
- Choose the right metrics for measurement
- Meet Meaningful Use requirements
- Put quality governance model in place



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# Preparing for Reimbursement Change

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## Estimating Your VBP Payments

Calculating a hospital's expected Medicare value-based incentive payment using current performance and goal targets for each process of care and HCAHPS measure.

Inputs		Outputs
<ol style="list-style-type: none"> <li>1 Current performance and goal targets for each process of care and HCAHPS measure</li> <li>2 Total Inpatient Medicare Payments for the most recent year (HCRIS data which is available in Press Ganey's Data Advantage tool)</li> <li>3 Adjustments to Medicare payments (provided by hospital) including:                             <ul style="list-style-type: none"> <li>• Medicare Outlier Payments</li> <li>• Indirect Medical Education Payments</li> <li>• Disproportionate Share Payments</li> <li>• Low-Volume Adjustment Payments</li> </ul> </li> <li>4 Provider number for the hospital being analyzed in order to auto-populate baseline performance</li> </ol>		<ol style="list-style-type: none"> <li>A <i>Performance Score</i> – Calculates achievement and improvement points for each measure, HCAHPS consistency score, and total performance scores</li> <li>B <i>Performance Dashboard</i> – Displays current performance on each measure relative to the achievement threshold and benchmark, estimates current percentile for each measure, and identifies whether performance has improved since baseline</li> <li>C <i>Impact Analysis</i> – Estimates amount of the base operating DRG withhold, and the range of VBP impact using CMS estimated incentive payments for the worst and best performing hospital</li> <li>D <i>Performance Analysis</i> – Calculates the VBP incentive payment and net VBP impact for a variety of linear exchange function slopes using both current performance and performance goals</li> </ol>
<b>Methodology</b>		
<ul style="list-style-type: none"> <li>▪ Applies formulas contained in the final rule to calculate the total performance score for a given hospital</li> <li>▪ Translates the hospital's score on each measure to percentiles by using the "PercentRank" function which determines the relative standing of that hospital's score compared to all hospital scores on that measure</li> <li>▪ Estimates VBP incentive payment and net VBP impact for linear exchange function slopes ranging from 1.5 to 2.5, and provides the breakeven Total VBP Performance Score for each slope (<math>1 / \text{Slope} = \text{Breakeven Score}</math>).</li> </ul>		

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## Estimating Your VBP Payments – Suggested Outputs

### A Performance Score

The screenshot shows a 'Performance Score' dashboard with a 'Default View' section and a table of scores. The table has columns for 'Metric', 'Score', and 'Weighted Score'. The 'Metric' column lists various quality and safety metrics, and the 'Score' column shows values ranging from 0 to 100. The 'Weighted Score' column shows values ranging from 0 to 100.

### B Performance Dashboard

The screenshot shows a 'Performance Dashboard' with a grid of metrics. Each metric has a status indicator (green, yellow, or red) and a 'Performance Point' value. The total VBP Performance Score is 80%.

### C Impact Analysis

	LOW	HIGH
Total Inpatient Medicare Payments	\$780,163,767	\$780,163,767
+ Medicare Value Payments		
+ Indirect Medical Education Payments		
+ Disproportionate Share Payments		
+ Longitudinal Adjustment Payments		
Net Operating DRG Payments	\$780,163,767	\$780,163,767
Percent reduction to Base Operating DRG	1%	1%
Base Operating DRG Withhold	\$2,801,638	\$2,801,638
CMS Selected Range of Incentive Payments (percentage of withhold earned basis)	3-30%	101-300%
CMS Selected Incentive Payments	\$92,718,619	\$5,780,870
Range of VBP Impact	(\$2,708,919)	\$2,280,868

### D Performance Analysis

Total VBP Performance Score (BASED ON PERFORMANCE SCORE CALCULATION)	CURRENT		GOAL
	20%	50%	
Estimated Incentive Payment by Percentile (BASED ON PERCENTILE PAYMENT CALCULATION)			
5th Percentile	\$88,112	\$88,112	\$88,112
5th Percentile	\$1,758,897	\$1,758,897	\$1,758,897
5th Percentile	\$1,784,529	\$1,784,529	\$1,784,529
5th Percentile	\$7,715,816	\$7,715,816	\$7,715,816
5th Percentile	\$2,551,027	\$2,551,027	\$2,551,027
5th Percentile	\$2,422,075	\$2,422,075	\$2,422,075
5th Percentile	\$2,502,585	\$2,502,585	\$2,502,585
5th Percentile	\$4,705,850	\$4,705,850	\$4,705,850
100th Percentile	\$8,080,516	\$8,080,516	\$8,080,516
Estimated VBP Percentile (based on provider percentile calculations)	65	77	
Estimated Incentive Payment at Percentile (Estimated Not Reported as Possible)	\$2,827,914	\$3,223,919	\$3,223,919
Potential Increase in Payment by Achieving Goal	(\$753,765)	\$449,596	



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## Quality Metric Framework

The quality measurement framework below maintains focus on superior performance for mandatory metrics, improves performance in key areas, and differentiates performance for emerging opportunities.

	Bare Minimums	Strategic Priorities	Emerging & Market Differentiating
<p>"Page 1" of Scorecard: ~10 metrics targeted for improvement</p> <p>↑</p> <p>↓</p> <p>"Page 2" of Scorecard: metrics tracked for performance</p>	<p><b>Objective:</b> Maintain superior performance on publicly reported and incentivized metrics</p> <ul style="list-style-type: none"> <li>1 composite of publicly reported metrics tied to financial penalties or incentives</li> <li>Goal – performance that avoids penalties and earns incentives</li> </ul>	<p><b>Objective:</b> Align quality improvement efforts with system and hospital strategic priorities</p> <ul style="list-style-type: none"> <li>~5 system level goals aligned to key improvement areas <b>AND</b></li> <li>~3 site specific goals that are aligned with system level key improvement areas</li> <li>Goal – focus performance improvement efforts on key quality areas</li> </ul>	<p><b>Objective:</b> Promote market differentiating performance for emerging opportunities</p> <ul style="list-style-type: none"> <li>1 system-level "stretch" goal that is intended to differentiate from competitors <b>OR</b></li> <li>1 site specific goal that addresses a local market differentiation opportunity</li> <li>Goal – create a differentiated performance "gap" between competition</li> </ul>
	<ul style="list-style-type: none"> <li>Individual process of care metrics that roll up to the system level composite</li> <li>Metrics that are mandatory to report, but that are not prioritized as being most important</li> <li>Metrics that have been consistently met or exceeded</li> </ul>	<ul style="list-style-type: none"> <li>Individual metrics that roll up to a strategic priority composite</li> <li>Metric that were previously strategic priorities but have reached a high level of performance (if the metric does not become a bare minimum)</li> </ul>	<ul style="list-style-type: none"> <li>Emerging metrics that are priorities, however they lack benchmarks for target setting</li> <li>Emerging metrics addressing areas where the organization does not have a performance gap</li> </ul>



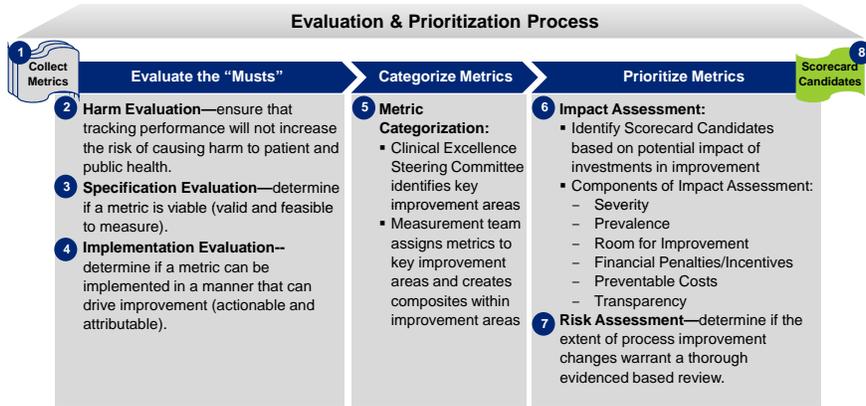
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## Metric Evaluation and Prioritization Process

To identify the most impactful metrics, a process with the following key objectives was developed:

- **Rigorous:** data-driven, structured approach that results in informed decisions about quality measures
- **Dynamic:** ability to anticipate changes in the quality landscape and respond swiftly as necessary
- **Transparent:** involves subject-matter experts and socializes rationale for measure selection
- **Sustainable:** repeatable and documented process that prioritizes quality improvement efforts



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## Scorecard Template

The scorecard focuses the organization on a balanced set of the most impactful metrics that are aligned with regulatory, system, and hospital priorities.

	Composite Metrics (Example)	Target / Performance
Bare Minimum		AMH BHC BJH BJSP BJWC CCH CHI MSAC MBS PHC PWHC SLCH
1. Value-Based Purchasing	VBP Composite	
<b>Strategic Priorities – System Key Improvement Areas</b>		
2. Appropriate Care - A measure of whether the patient received all recommended treatment for which they are eligible	Stroke process of care composite	
3. Patient Safety - A measure of errors in clinical care, whether by action or inaction, resulting in injury to patients	Preventable Harm Composite (Adverse drug events, healthcare associated infections, patient safety events, falls, pressure ulcers, VTE, etc.)	
4. Mortality - A measure of patient deaths while in the hospital after specific interventions	Risk-adjusted operative mortality (including CABG, AAA, etc.)	
5. Readmissions - A measure of admitted patients who return to the hospital after specific interventions	30-day severity-adjusted hip joint replacement readmission	
6. Overuse - Measures aimed at safely reducing the burden of unscientific, inappropriate, and excessive care	Hospital Outpatient Imaging (Abdomen and Thorax CT use of contrast material)	
<b>Strategic Priorities – Site Specific Key Improvement Areas</b>		
7. Appropriate Care	Cardiac surgery process of care composite	
8. Patient Safety	Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)	
9. Mortality	Risk-adjusted operative mortality for AVR	
<b>Emerging &amp; Market Differentiating</b>		
10. To be Determined	Risk-adjusted survival (oncology/transplant)	

**Benefits of Scorecard Framework**

- **Aligned to national and organizational priorities**
  - Incorporating national priorities ensures improvement efforts promote regulatory compliance and maximize incentives
  - Identifying key improvement areas helps align quality improvement with strategic priorities
- **Balanced scorecard**
  - Increasing the scope of the scorecard to include process of care, outcomes-based, and efficiency metrics will help promote balance in quality improvement efforts
- **Effective use of resources for quality efforts**
  - Grouping metrics based on publically reported composites, medical conditions, or relevant interventions will help focus process improvement efforts on high impact areas

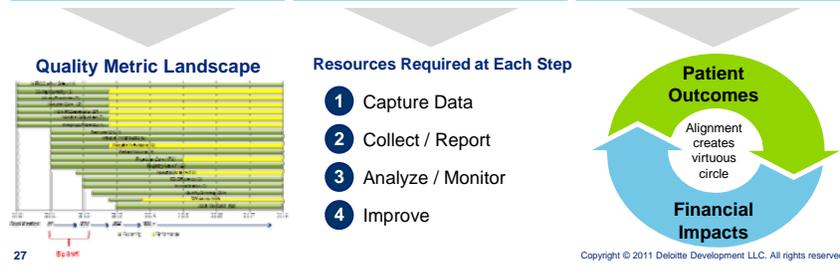
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## Too Many Metrics, Not Enough Time

The growth in quality metrics (HITECH, PPACA), number of resources required, and the potential patient and financial impacts have made it critical for providers to evolve their approach to quality governance.

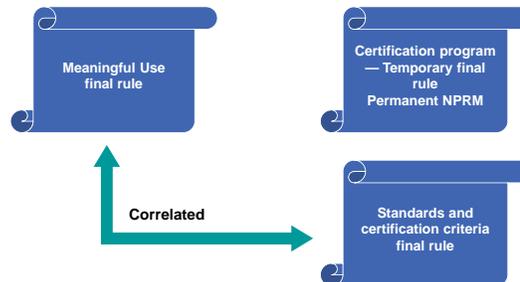
Growth and Complexity of Quality Metrics	Considerable Resources Required	Patient Outcomes & Financial Impacts
<ul style="list-style-type: none"> <li>Quality metrics are being developed by regulators, payors, and national quality groups</li> <li>Metric developers have not been coordinated (duplicate metrics)</li> <li>Metrics are becoming more precisely specified and more challenging to collect and monitor</li> <li>Over 350 quality metrics will be required for reporting by 2013</li> </ul>	<ul style="list-style-type: none"> <li>Similar metrics are being tracked using different methodologies, leading to duplicative effort</li> <li>Inability to extract data elements and calculate metrics electronically using an EMR results in significant manual abstraction and data validation</li> <li>Monitoring metrics and vendor reporting capabilities is challenging</li> </ul>	<ul style="list-style-type: none"> <li>Focusing on evidence-based metrics shown to improve patient outcomes will improve quality</li> <li>Shift in focus from reporting to performing on metrics has potential to have significant financial impact                             <ul style="list-style-type: none"> <li>- Value-based purchasing</li> <li>- Meaningful Use</li> <li>- Hospital readmissions / HACs</li> <li>- Medicare shared savings (ACO)</li> </ul> </li> </ul>



## Meaningful Use: Fitting the regulatory pieces together

Meaningful Use is comprised of three pieces of regulation with one goal: to improve the quality of health care by leveraging health information technology. These regulations are inextricably tied together. They will change over time, together. And after much anticipation, they have been finalized for Stage 1.

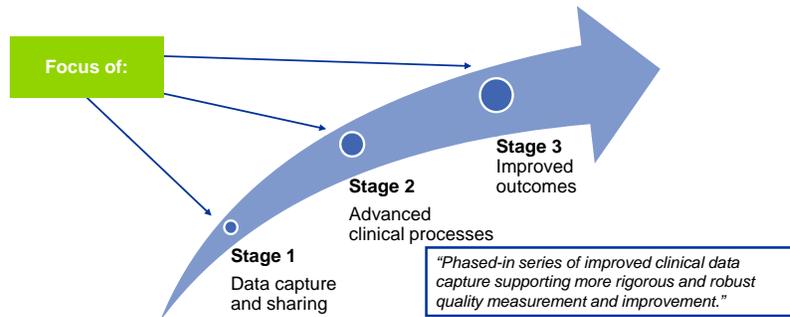
### “Meaningful user of certified EHR technology”



## Staging of Meaningful Use

- The stages of Meaningful Use represent a graduated approach to arriving at the ultimate goal. Thus, the goals for "Stage 3" Meaningful Use criteria represent overarching goals which, CMS believes, are attainable in the future.
- Meaningful Use regulations will be further defined/refined in an "escalator" type approach in three, bi-yearly stages: 2011, 2013, 2015.
- As regulations increase in specificity over time, incentive payments decrease until penalties begin.

*Moral of the story is: it pays to adopt early!*



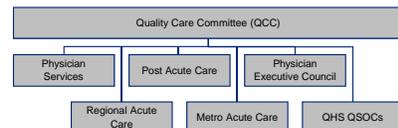
Connecting for Health, Markle Foundation "Achieving the Health IT Objectives of the American Recovery and Reinvestment Act" April 2009  
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## Sample Quality Governance Model

	Identify Measures	Prioritize Measures	Define Measures	Sign Off	Monitor Performance
<b>Description</b>	<ul style="list-style-type: none"> <li>Primary sources include:                             <ul style="list-style-type: none"> <li>Federal Register</li> <li>Hospital Compare</li> <li>NQF</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Goals retreat to debate and vote on metrics</li> <li>Divide attendees into teams to discuss priority areas (2 teams for each: patient safety, clinical efficiency and outcomes)</li> <li>Identify 7-8 quality goals based on importance for current and future operation</li> </ul>	<ul style="list-style-type: none"> <li>Target level is set for the entire system</li> <li>Each hospital negotiates its target based on its current position</li> <li>Produce goals definitions document (i.e., includes definitions for numerators/denominators)</li> </ul>	<ul style="list-style-type: none"> <li>QCC endorses goal targets</li> <li>QCC chair reviews specific goals and publishes to the rest of the committee for comments</li> <li>Management Action Plan                             <ul style="list-style-type: none"> <li>Develop matrix showing each hospital's plan to improve performance on specific metrics</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Monthly management dashboard</li> <li>Monthly KPI report</li> <li>Monthly QSOC meetings</li> </ul>
<b>Owners</b>	<ul style="list-style-type: none"> <li>One individual, part-time consultant who was a former employee</li> </ul>	<ul style="list-style-type: none"> <li>CEO, CMO, CME, quality leaders from acute care</li> <li>120-150 leaders at retreat</li> </ul>	<ul style="list-style-type: none"> <li>Quality Care Committee (QCC)</li> <li>Senior Management</li> </ul>	<ul style="list-style-type: none"> <li>QCC chair</li> <li>Quality and Safety Operations Committees (QSOC)</li> </ul>	<ul style="list-style-type: none"> <li>QSOC</li> </ul>
<b>Timing</b>	<ul style="list-style-type: none"> <li>Ongoing/Year-round</li> </ul>	<ul style="list-style-type: none"> <li>3-4 months (May-August)</li> </ul>	<ul style="list-style-type: none"> <li>3 months</li> </ul>	<ul style="list-style-type: none"> <li>1 month</li> </ul>	<ul style="list-style-type: none"> <li>Monthly</li> </ul>

### Governance

- Quality Care Committee (QCC)
- Each facility has the opportunity to develop hospital specific goals



### Leading Practices

- Align the scorecard to the organization's key priorities
- Each facility is encouraged to supplement system goals with hospital-specific metrics
- Hold large goals retreat to establish buy-in
- Transparency to drive process improvement: each hospital develops actions plans that are aggregated into a matrix and shared across the system; the QSOC meets monthly to provide updates
- Definitions of Quality Goals Measures are developed to clarify the meaning of everything from key priorities to inclusions / exclusions to certain metric calculations

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## Sample Quality Governance Model

	Identify Measures	Prioritize Measures	Define Measures	Approve Measures	Monitor Performance
<b>Description</b>	<ul style="list-style-type: none"> <li>Primary sources include:                             <ul style="list-style-type: none"> <li>-CMS</li> <li>-AHRQ</li> <li>-CDC</li> <li>-NDNQI</li> <li>-Magnet Regulations</li> <li>-HCAHP (currently less focus)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Three pages of metrics (200 total)                             <ul style="list-style-type: none"> <li>-Page 1: 8-10 metrics, with ~1/3 new each year</li> <li>-Page 2: Emerging and retired metrics</li> <li>-Page 3: State mandated reporting metrics</li> </ul> </li> <li>Process has been informal but attempting to make it more rigorous</li> </ul>	<ul style="list-style-type: none"> <li>Use Red/Yellow/Green lights with green meaning 90<sup>th</sup> percentile</li> <li>Mixture of outcomes and process of care metrics                             <ul style="list-style-type: none"> <li>-Outcomes = 2/3</li> <li>-Process of Care = 1/3</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Metrics are discussed at the hospital level before proceeding to the system</li> <li>Currently decisions on which metrics to track are vetted with a small group of clinical leaders; desire for more robust vetting process</li> <li>The Board provides final approval</li> </ul>	<ul style="list-style-type: none"> <li>Misses are reported and reviewed on a monthly basis</li> <li>Publishing lessons-learned has helped promote knowledge sharing across the system</li> <li>All Page 1 metrics have support teams to drive improvement</li> </ul>
<b>Owners</b>	<ul style="list-style-type: none"> <li>System-level Quality department with some support from strategic planning</li> </ul>		<ul style="list-style-type: none"> <li>Patient Safety and Quality Committee</li> <li>Quality Strategy Team (subset of above)</li> </ul>	<ul style="list-style-type: none"> <li>Hospital-level executives</li> <li>The Board</li> </ul>	<ul style="list-style-type: none"> <li>Campus Performance Improvement Teams (CPIT)</li> <li>Patient Safety and Quality Committee to Board</li> </ul>
<b>Timing</b>	<ul style="list-style-type: none"> <li>Ongoing/year-round</li> </ul>	<ul style="list-style-type: none"> <li>3 months</li> </ul>			

**Governance**

All teams and committees are inter-disciplinary in nature including strong physician leadership

```

graph TD
    Board[Board] --> QCC[Quality of Care Committee]
    QCC --> SST[System-Level Quality Strategy Team]
    QCC --> SC[System-Level Scorecard Committee]
    SST --> MEC[Hospital-Level Medical Executive Committee]
    SC --> CPIT[Hospital-Level Campus Performance Improvement Team (CPIT)]
            
```

**Leading Practices**

- The scorecard is balanced with 2/3 currently devoted to outcomes metrics and the other 1/3 to process of care metrics; use a mixture of system level and hospital specific metrics
- Metrics are prioritized into 3 pages: most critical, emerging/retired, and state reported metrics
- Every individual is incentivized is based on system, hospital, and individual performance (equally weighted with 1/3 each)
- IT is heavily involved in process improvement efforts from the CIO prioritizing anything related to patient safety to the IT representation on the CPITs

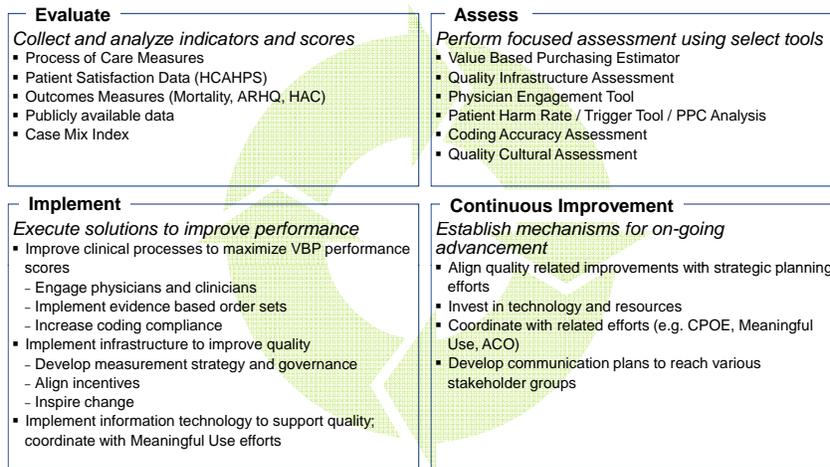
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# Emerging Leading Practices

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## Improving Value is a Continual Process

VBP is the first of many changes in the payment landscape that will increase the focus on clinical quality, safety and patient satisfaction. We expect state and commercial payors to follow Medicare's lead, and as a result the amount of reimbursement "at-risk" will steadily rise.



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## Capabilities Emphasis

Organizational capabilities should be realigned to the emerging reimbursement system

Organizational Capabilities	Capability Component	Cost, Quality, and Payment Alignment					
		Lower					Higher
		Fee for Service	Pay For Performance	Penalties for Adverse / Preventable Events	Episodic Bundling	Disease / Chronic Care Management	Total Health Management
People & Culture	Culture and Change Management	Establishing Learning Organization		Leading with Quality		Managing Long-Term Conditions	Engaging the Community
	Management and Governance	Informal Physician Leadership		Formal Acute-Care Physician Leadership		Communities of Practice	
	Operating Model	Department Structure		Episode-Focused Service Lines		Cross-Continuum Product Lines	Community Collaboratives
	Compensation and Incentives	Productivity-Based				Outcomes-Based	
Business Intelligence	Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal		PMPM
	Quality Reporting	Core Measures	Process Measures		Outcome Measures	Condition Measures	Population Indicators
	Business Case	Supply/Drug & Productivity		Medical / Surgical Interventions			Lifestyle Interventions
	Decision Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info		Health Risk Assessment, Biometrics, and Predictive Modeling
Performance Improvement	Process Engineering	Identifying Service Variability		Increasing Reliability within Care Bundles		Optimizing Care Pathways across the Continuum	
	Evidence-Based Medicine	Patient Safety		Clinical Value Bundles		Condition Management	Wellness
	Consumer Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	
Contract & Risk Management	Payer and Provider Contract Mgmt	Negotiating Pricing		Balancing Cost and Quality Aims		Network Development / Funds Distribution	
	Actuarial			Estimating Exposure		Predicting Outcomes	
Enabling Technology	Medical Technology	Facility-Based		Ambulatory-Focused		Home-Based	
	Information Systems	Standardizing Patient Accounting		Supporting Clinical Work Flows / Connecting Data from Disparate Systems		Enabling Medical Management	

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## Leading Practices in Quality Metrics

Through interviews with a select group of comparator organizations, leading practices have been identified for prioritizing metrics, establishing "buy-in," and enabling process improvement.

Key Activity	Leading Practice
<b>Prioritize Metrics</b>	<ul style="list-style-type: none"> <li>Focus attention on a manageable number of metrics</li> <li>Use a combination of system and hospital metrics</li> <li>Frame scorecard around key organizational priorities for quality improvement</li> <li>Track individual metrics, while incentivizing improvement on composites and outcomes</li> <li>Assess performance and monitor emerging metrics before they become incentivized metrics</li> </ul>
	<ul style="list-style-type: none"> <li>Align business and physician leadership</li> <li>Promote performance transparency across organization</li> <li>Incentivize down to the staff level based on system, hospital, and individual performance</li> <li>Enable the highest levels of leadership to be active participants in quality governance</li> </ul>
	<ul style="list-style-type: none"> <li>Use combination of system and hospital support teams to implement process changes</li> <li>Develop and share action plans to drive improvement</li> <li>Learn from episodes with poor outcomes through the sharing of case studies</li> <li>Engage health information technology resources in process improvement efforts</li> </ul>

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## Waste and Variation in the System

Harmful waste and improved efficiency should be a primary target for organizations seeking to improve value.

### **Insurers are imposing new measures and eliminating reimbursement for waste:**

- In late 2008, CMS stopped reimbursing healthcare providers for 11 "never events" considered reasonably preventable errors in healthcare
- In 2010, Blue Cross and Blue Shield companies followed suit and established a payment policy prohibiting reimbursement for hospital acquired conditions or "never events"
- Provider error, unnecessary care, avoidable admissions and lack of care coordination make up 40% of Medicare spending

### **Providers are identifying opportunities to eliminate variation, waste and harm:**

- In 2008, approximately 1 of 7 hospitalized Medicare patients experienced one or more adverse events
- Hospitals can save roughly 9% of total inpatient hospital costs by eliminating potentially preventable conditions
- The system spent \$14 billion treating 115.3 million people (13.9%) that visit the ER each year without an urgent condition
- Misuse of antibiotics for viral infections is estimated to cost an annual \$1.2 billion
- Chronic disease management (through medical homes) has been shown to reduce ED admissions by 7.3-29%
- Only 55% of patients receive evidence-based care
- 20-30% of costs could be reduced if all regions could safely reduce care to the level observed in low-spending regions with equal quality (Source: Dartmouth Atlas)

## Potential for Savings from Reducing Potentially Preventable Complications Exists

The OIG Report found that physician reviewers determined that 44% of adverse and temporary harm events were clearly or likely preventable and 51% were not preventable.<sup>4</sup>

Table 2a: Estimates, Confidence Intervals, and Key Statistics	OIG Study			Extrapolation		
	Estimated Percentage of Patients	95-Percent Confidence Interval		Estimated Percentage of Patients	95-Percent Confidence Interval	
		Lower Bound	Upper Bound		Lower Bound	Upper Bound
<b>Preventability Classification for All Adverse Events and Temporary Harm Events</b>						
Preventable events	44.04%	38.06%	50.19%	4,043	3,494	4,608
Clearly preventable events	9.27%	6.53%	13.01%	851	600	1,194
Likely preventable events	34.77%	29.20%	40.79%	3,192	2,681	3,745
<b>Not preventable events</b>	<b>51.32%</b>	<b>45.22%</b>	<b>57.39%</b>	<b>4,712</b>	<b>4,152</b>	<b>5,269</b>
Clearly not preventable events	18.21%	13.92%	23.47%	1,672	1,278	2,155
Likely not preventable events	33.11%	27.59%	39.14%	3,040	2,533	3,593

### Estimated Amount that Potentially Preventable Conditions (PPCs) Add to a Hospital's Inpatient Costs<sup>7</sup>

Fuller, et. al found that potentially preventable events (PPCs) are estimated to add 9.4 % to 9.7% to a hospital's inpatient costs.<sup>7</sup> Across three facilities, this amounts to approximately \$31 M for 2009 discharges when looking at recorded direct variable costs alone

Facility	9.4 %	9.7%
Hospital A	\$ 5.04 M	\$ 5.20 M
Hospital B	\$ 8.16 M	\$ 8.42 M
Hospital C	\$ 17.39 M	\$ 17.94 M
<b>Total</b>	<b>\$ 30.59 M</b>	<b>\$ 31.56 M</b>

1. Study Source: "ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES" Dept of Health and Human Services, Office of Inspector General, November 2010  
 2. OIG Study = analysis of hospital stays and Medicare claims for 780 Medicare beneficiaries discharged in October 2008  
 3. Estimated # of Patients = 34,105 inpatient encounter discharges with general payor listing classified under Medicare for 2009 across the 4 facilities  
 4. Physician reviewers assessed events as not preventable when they occurred despite proper assessment or when the patients  
 5. Given the small proportions, confidence intervals for projected numbers exceed 50 percent relative precision  
 6. "Estimating the Costs of Potentially Preventable Hospital Acquired Complications" Richard L. Fuller, M.S., Elizabeth C. McCullough, M.S., Mona Z. Bao, M.S., and Richard F. Averill, M.S., 2009 Health Care Financing Review vol 30.4  
 7. Study Source: "Estimating the Costs of Potentially Preventable Hospital Acquired Complications", 2009. For PHP, \$ estimates based upon 2009 discharges. Direct Variable Costs (DVC) was used rather than Total Costs due to availability of information. DVC information not provided by UVMC.  
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## Estimated Annual Impact of AE Reduction Program Portfolio

Financial Outcomes Associated with Adverse Events*			
	FY07	FY08	FY09
<b>per DC total cost (DCs having 1+ AE)*</b>	<b>\$24,773</b>	<b>\$24,820</b>	<b>\$24,295</b>
<b>Total qualifying hospital discharges</b>	<b>60,021</b>	<b>61,267</b>	<b>64,795</b>
<b>AE incidence rate</b>	<b>22.8%</b>	<b>19.6%</b>	<b>17.9%</b>
<b>AEs Projected</b>	<b>13,685</b>	<b>11,945</b>	<b>11,598</b>
<b>Total cost for DCs with 1+ AE (\$M)</b>	<b>\$339.0</b>	<b>\$294.1</b>	<b>\$261.7</b>
<b>Cost per 60,000 DCs (\$M)</b>	<b>\$338.9</b>	<b>\$288.1</b>	<b>\$260.8</b>
<b>Cost change over FY07 baseline** (\$M)</b>	<b>NA</b>	<b>-\$50.8</b>	<b>-\$78.1</b>
<b>Percent Increase Over Prior Year</b>	<b>NA</b>	<b>-15.0%</b>	<b>-27.1%</b>

\*Only hospital-acquired AEs are considered; \*\*For population of 60,000 patients

**\$77M represents ~2.3% of Net Hospital Operating Income**

## Linking Quality and Financial Results

Leading providers use improvements in quality to drive financial results and create disciplined measurement of both quality and financial outcomes.

### Sepsis Screening

- A large provider system developed a Web based Systemic Inflammatory Response Syndrome (SIRS) screening tool to promote early recognition of sepsis and reduce sepsis-related mortality.
- The screening tool measures 4 key indicators for sepsis and SIRs parameters and assigns a composite score, allowing nurses to know when to intervene and initiate the protocol.
- Use of the tool for patients admitted to the hospital reduced sepsis-related mortality from 35.1% to 23.3% over 2 years. Mortality in the SICU has been maintained at 14 – 16% over the last 12 months. Most importantly, we have saved 159 lives over 2 years!

### Diabetes Care Program

- A diabetes care program at a midwest based integrated healthcare system, has increased the number of insured patients receiving optimal diabetes care by 129%.
- Twenty-five percent of Medical Group patients were under perfect control for their diabetes (statewide average is 19%).
- The improved diabetes care means that about 115 heart attacks, 925 cases of diabetes-related eye disease, and 155 amputations were avoided over four years; this translates to savings of \$15 million a year on diabetes care related costs.
- To encourage results, the system provides employee bonuses based on the percentage of patients who receive optimal care for diabetes.

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## Conclusion

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## Fundamental Change is Required

Provider organizations must change their primary business model to focus on improved clinical outcomes in addition to financial outcomes.

Key Activity	Leading Practice
<b>Anticipate rather than respond</b>	<ul style="list-style-type: none"> <li>Understand CMS and payer changes</li> <li>Scan the horizon for emerging metrics and practices</li> <li>Develop programs in anticipation of change</li> </ul>
<b>Develop real time decision support</b>	<ul style="list-style-type: none"> <li>Implement technology to support care givers at bedside</li> <li>Use retrospective analytic tools to measure</li> <li>Provide real time surveillance for adverse events</li> </ul>
<b>Utilize clinical data for clinical improvement</b>	<ul style="list-style-type: none"> <li>Invest in clinical data analysts to harvest the power of the clinical record</li> <li>Produce dashboards populated by data from clinical systems</li> <li>Automate clinical reporting</li> </ul>
<b>Move from an institutional record to patient centered</b>	<ul style="list-style-type: none"> <li>To understand the true determinants of health, a complete medical record is necessary</li> <li>Site of care records cannot support episode based reimbursement</li> </ul>
<b>Position for population care</b>	<ul style="list-style-type: none"> <li>Define the population – those that seek care and those that don't</li> <li>Determine the clinical characteristics of the population</li> <li>Design care to impact health not just illness</li> </ul>

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## Unresolved Issues Must be Addressed

Outstanding issues put provider organizations at financial risk until resolved

Issue	Impact
<b>Value measurement</b>	<ul style="list-style-type: none"> <li>Financial impact is only one dimension of value</li> <li>Health impact is measured in different ways – morbidity, quality of life, etc.</li> <li>How to choose between investing in lab turn around time or discharge medication instructions</li> </ul>
<b>Best timing</b>	<ul style="list-style-type: none"> <li>Doing the right thing too early may have negative financial implications (quality leaders have experienced negative top line impact)</li> <li>Saving dollars for Medicare reduces provider reimbursement (readmissions in FFS)</li> <li>Too late to implementation can result in decreased reimbursement (VBP is winners and losers)</li> </ul>
<b>Focus</b>	<ul style="list-style-type: none"> <li>Over 300 new metrics in pipeline</li> <li>Multiple payers have different forms of VBP</li> <li>Each state will be developing its own reform strategy</li> </ul>



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