

SPAHQ *spring 2003* update

NEWSLETTER OF THE SOUTHEASTERN PENNSYLVANIA ASSOCIATION OF HEALTHCARE QUALITY

VOL. 2 ISSUE 2

SPAHQ Bi-monthly Subgroup Meetings

WHERE: Temple University Hospital
3401 N. Broad St.
Philadelphia, PA. 19140

WHEN: 3rd Thursday of every month
from 3 to 5 PM

**Safe convenient parking behind the hospital.
Light refreshments will be served.*

June- Host: Nancy McMann

Core Measures

- How is it going?
- What actions are you taking in response to findings?
- Any concerns with vendors?

July- Host: Nancy McMann

PHC4

- Responses to data
- How do you prepare for media release of data
- Any ongoing activity/data review
- Any proactive programs

Aug.- Host: Maryellen Reilly

Software Product Review

- Pros/Cons of each product-implementation, support, etc.
 - Canopy
 - ECIN
 - TQ

Sept.- Host: Nancy McMann

Patient Safety Goals

- Implementation activities
- Educational initiatives
- New goals

Nov.- Host: Host: Maryellen Reilly

HIPAA

- Post-implementation issue
- Public response to HIPAA

president's message

Mary Ellen Reilly, MS, MT

Happy Spring. I trust that you are keeping warm in this crazy weather. Isn't it difficult to "Think Spring" when you come home to six inches of snow and the kids are for yet another snow day! Between the war and the weather, life is certainly inconsistent with what we are used to. Changes are looming on the professional side as well. JCAHO has changed the survey process yet again. It is no longer an option to set up an intensive preparation process every three years, selecting specific charts for review, preparing interview teams, etc. Those days are gone!. The new Tracer Methodology compels us to consider "continuous survey readiness", rather than the previous triennial survey preparation madness. In the long run, this may end up being the best thing JCAHO ever came up with, but it will certainly be challenging!. Our SPAHQ Spring conference will be partially dedicated to improving our under-

standing of the mechanics of the Tracer Methodology process.

On the Case Management side of our business, we are also experiencing great changes. As beneficiaries become increasingly responsible for co payments and deductibles, we will be challenged to implement efficient collection processes, or face further financial difficulties. In addition, the managed care organizations are revising their approaches to contracting and utilization management. This is the second topic that we have included in the SPAHQ Spring conference. All of these changes make it critical for QI and UM professional to link with colleagues and network to share the "learning" Your SPAHQ Board members have planned a full year of networking meetings and conferences to address our ever changing professions. This newsletter contains a listing of the offerings. Mark your calendars and try to attend as many of these as your schedule permits - both networking meetings and conferences. See you there!

"Medicare Modernization", a Top Priority for Congress in May:

Hospital Community Must Protect Provider Payments

With an eye towards adding prescription drug coverage to Medicare, the U.S. House is expected to work on a Medicare "modernization" plan beginning in early May. House Speaker Dennis Hastert (R-Ill.) said he hopes the House can vote on a plan before Memorial day. The concern for hospital and health systems is that Medicare modernization not be subsidized by provider payment cuts. The budget resolution just approved by Congress set aside \$400 billion for a Medicare prescription drug and modernization program, while also assuming savings of 11.2 billion over 10 years resulting from medical liability insurance reform. If liability reform savings do not materialize or the cost of the prescription package exceeds the budgeted amount, payments to hospitals remain vulnerable, even though the budget resolution eliminated mandatory cuts to both Medicare and Medicaid." Pennsylvania members on the House Speakers Hastert new Prescription Drug Action Team: Rep Jim Gerlach (R- Downington) and Melissa Hart (R-Bradford Woods).

Who's Really Looking?

In quiet offices and comfortable conference rooms all of us evaluate the quality of care we deliver. Our evaluation of length of stay, delays in care, interwoven with our risk data, mortality and morbidity all tied together with patient satisfaction. What does it really mean to the health care consumer when our emergency departments are full and waiting times for beds are the highest in history. Who is really looking when the PHC4, JCAHO and the state publish our results? Does the consumer really focus on quality when they select a health care facility or are our facilities open, and close by so they come?

The answer is really both. Today our health care consumer is far more savvy. In going out on the internet, place health care quality in the search engine. There are over 160,000 sites that speak to quality. What to look for, how to choose your physician, hospital and long term care facility. Just in the first two pages a consumer can see home pages from Consumer Coalition for Quality Health Care, JCAHO, NCQA, The Agency of Health Care Research and Quality, Health Grades, Medicare Nursing Home Compare and the Presidents Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Who knew it was right at our consumers fingertips all the time. The Internet has been a friend to the consumer, making them more informed and challenging us as health care providers.

Within the Internet, the health care consumer using Health Grades can identify by procedure, who is providing 5 star quality outcomes. Identify the best nursing homes through the Medicare Nursing home site. And focus on how to select a health care provider (Physician or hospital). The Presidents commission focuses on reducing health care errors, appropriate us of health care

resources and elimination of variations in clinical practice using evidenced based best practice.

Today's consumer is knowledgeable, they have access to information that 10 years ago was not even heard of and in some instances we were grateful for it. It enabled the provider to be arrogant and advise our consumers that we knew best even if we didn't. Linked to their access to information, today's consumer is mobile. It is not uncommon for an individual to drive the extra distance to secure the service and quality they desire. Our health care system is changing, the demands on the provision of quality of care are high, and they can no longer be spoken of quietly in our conference rooms. Health care providers must be willing to take charge of their data, be willing to make the hard decisions about marginal service and focus on the informed customer.

2003 Membership is Due !

Have you renewed your SPAHQ membership? If not time is running out. Stay in touch with your peers and colleague's, networking is the key to new information and to stay in touch with the issues surrounding us today. As a reminder personal of business checks that are returned for insufficient fund will result in the application of the bank fees to the member. Contact Sue Detwiler with any questions that you may have.

SPAHQ Spring Conference: Mark Your Calendars!!

"Back to the Future" - What will JCAHO and Managed Care look like Next Year and Beyond!

This year's spring conference will focus on two topics on major interest to all of us. Deb Ondeck from Joint Commission Resources will speak about the JCAHO 2004 standards and survey process. Deb works with health care organizations through a joint program between HAP and the Joint Commission focused on Continued Survey Readiness.

The conference will also focus on Managed Care and where it will be in the next five years. Henry DePhillips, MD, Medical Director, Independence Blue Cross will present his views followed by Michael Dandorph, Associate Vice President, Managed Care and Payor Relations, University of Pennsylvania Health System. Are their views in sync? How can we, in all aspects of the health care delivery system, prepare rather than respond to the anticipated changes.

The conference will be held from 8:30am till 4pm The fee is \$50.00 and lunch is included. This is a great value for an all day conference! Watch for the brochure and registration form in the next few weeks.

So ease into the weekend by spending Friday with us it will be well worth it!

Date: Friday June 6, 2003

Location: To be announced

Speakers

am: Deb Ondeck,
Joint Commission of
Resources
pm: Henry DePhillips,
Medical Director at IBC
Mike Dandorph,
VP Managed Care
for UPHS
Fee: \$50.00 per person

CMS takes steps to crack down on inappropriate hospital outlier claims

The Centers for Medicare & Medicaid Services (CMS) proposed new regulations that will prevent further gaming of the outlier system. A few hundred hospitals in recent years have obtained the lion's share of these payments by manipulating their Medicare billing to maximize Medicare outlier revenues.

Hospitals receive an additional payment - called an outlier payment - if the estimated costs of an individual case exceed the Medicare payment rate by a threshold amount that is set by Medicare regulations. In the final hospital inpatient prospective payment rule for fiscal year 2003, the threshold amount was set at \$33,560. The threshold amount would remain the same in the proposed rule, but will be fully reviewed and evaluated during the comment period.

"The new policy will achieve a balance between paying hospitals fairly for high cost cases and limiting outlier payments to the 5 to 6 percent of total inpatient spending that Congress mandated," said CMS Administrator Tom Scully. "We anticipate that the changes we are announcing today will stop, and likely reverse, the recent trend toward a rapid upward spiral in the threshold for eligibility for outlier payments. As a result, we believe more hospitals will appropriately receive higher payments in the future."

Medicare generally pays hospitals a predetermined amount for a patient's stay, based on the average cost of providing care to a patient in a similar condition. The payment is set at an amount that will allow an efficiently operated hospital to earn a reasonable rate of return overall for the average patient. However, Medicare law recognizes that there are some cases that are more complicated and therefore more costly to treat and requires that CMS pay an additional amount to hospitals for these outlier cases. In the 2003 hospital payment update, CMS has set the outlier

threshold at a level projected to pay 5.1 percent of total payments for inpatient care for these outliers - about \$3.8 billion.

In recent years, the outlier spending targets were \$3.5 billion in 2000 and actual spending was \$5.3 billion; \$3.6 billion in 2001 while spending was \$5.5 billion; and \$3.7 billion for 2002, while spending was \$5.3 billion.

"Obviously this system is badly broken," said Scully. "CMS did not understand why spending was escalating beyond Congress' allotment and kept raising the outlier threshold. Now that CMS understands the gaming that led to this unintended spending, we are acting to end these practices."

Under current rules, in order to estimate the actual costs incurred by a hospital for a given case, Medicare uses the historical relationship between each hospital's costs and its charges. So long as hospital costs and hospital charges change at roughly the same rate, this estimate produces a relatively reliable result. However, if a hospital increases its charges dramatically relative to costs, the use of the historical relationship will yield higher outlier payments than would be appropriate. In addition, the longer the lag between the historical data and the current charges - currently two years the less accurate the estimate will be.

Each year, when CMS updates the hospital payment rates, it sets a threshold for outlier payments designed to keep them at the target of 5.1 percent of total payments under the DRG. As outlier claims (heretofore inexplicably) increased, the outlier threshold has gone up sharply - from \$14,050 in 2000 to \$33,560 in 2003 to stay within the 5.1 percent target. As a direct result, more hospitals have had to absorb the costs of complex cases, while a relatively small number of hospitals have been aggressively taking advantage of the current

rules, and receiving a growing portion of outlier payments.

"In December, we announced several steps we were taking to identify hospitals that appear to have engaged in schemes to obtain higher outlier payments than they were entitled to in good faith," said Scully. "In this rule, we are looking to the future to ensure that these practices do not continue — period."

Today's rule proposes three significant changes to prevent hospitals from manipulating the outlier formula:

- allows Medicare to use more recent data to calculate outlier payments.
- eliminates the use of a statewide average ratio of costs to charges for hospitals with very low computed cost-to-charge ratios.
- allows Medicare to recover overpayments if the actual costs of a case as reflected in the settled cost report are less than the provider had claimed. Overpayment recoveries would be subject to an adjustment to account for the value of the money during the time period it was inappropriately held by the hospital.

"With the rule we are proposing we are showing our intention to turn off the faucet to those hospitals that have been overcharging Medicare, while making sure that all hospitals will be paid appropriately for the care they provide to Medicare beneficiaries," said Scully. "This will ultimately provide relief to the many hospitals that have been denied legitimate payment for complex patients due to the inappropriate behavior of a small group of other hospitals."

The rule will be published as a notice of proposed rulemaking in the March 5 Federal Register with a 30-day comment period. Comments will be accepted until April 4, and a final rule will be published as soon as possible.

SPAHQ officers for 2002

SPAHQ officers are here to serve the membership. Feel free to reach out and become an active member of our organization.

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