




Quality Based Impacts to Medicare Payments


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Overview

- Origins of Quality Reporting
- Themes in Quality Reimbursement
- Quality Programs in Effect
- Sociodemographic Status


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History of Quality Measures

- Reporting measures
 - Institute of Medicine (IOM) - 1970
 - Agency for Healthcare Research and Quality (AHRQ) - 1989
 - Prevention Quality Indicators
 - Inpatient Quality Indicators
 - Patient Safety Indicators
 - Pediatric Quality Indicators, etc,
 - National Committee for Quality Assurance (NCQA) - 1990
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
 - Not integrated with CMS


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History of Quality Measures

- National Quality Forum (NQF) – 1999
 - Clearinghouse for endorsement of quality measures
 - Working groups of healthcare experts
 - Publishes detailed reports on measures
 - ACA mandates that all measures used for quality reimbursement factors are NQF- endorsed

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History of Quality Measures

- Quality Initiative launched by CMS in November 2001 as a voluntary program to “empower consumers with quality of care information” and to “encourage providers and clinicians to improve the quality of health care.”
 - This led to the Hospital Compare website.
- Hospital Inpatient Quality Reporting (IQR) Program
 - Deficit Reduction Act of 2005
 - Imposed a penalty for IPPS hospitals not reporting quality data – lose 2% of market basket update each year
- Model for other quality reporting

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National Quality Strategy (2011)

Better Care


PRIORITIES

1. Making care safer
2. Ensuring that each person and family are engaged
3. Promoting effective communication and coordination of care
4. Promoting the most effective prevention and treatment practices
5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care affordable

Healthy People/Healthy Communities
Affordable Care

Source: 2015 National Impact Assessment of CMS Quality Measures Report


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January 2015 Comments on Paying for Quality

- HHS Secretary Sylvia Mathews Burwell
- Goals for CMS
 - Payments fee-for-service Medicare via alternative payment models
 - As of end of 2014: 20%
 - Target 30% by end of 2016
 - Target 50% by end of 2018
 - Payments tied to quality or value measures
 - As of end of 2014: 80%
 - Target 85% by end of 2016
 - Target 90% by end of 2018


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VBP / Quality Themes

- Clinical processes
 - Mostly sourced through quality reporting programs
 - Measure adherence to best practice protocols
 - Measures frequently “top out” when industry compliance is uniform
- Outcomes
 - Readmissions, mortality, infection rates, “never events”
 - Standardized Rate = $\frac{\text{Predicted Rate}}{\text{Expected Rate}} \times \text{National Rate}$
- Patient satisfaction
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
 - “Top Box” response is the only response that matters
- Efficiency
 - Medicare spending (Parts A & B), normalized for geographic and facility specific factors


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Types of Comparisons

- Risk-adjusted outcomes
 - Better or worse than expected
- Score improvement / achievement
 - Establish nationwide benchmarks with older baseline data
 - Measure performance against benchmarks against baseline
 - Improve over provider's baseline score
 - Achieve a quality score


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Source of Performance Data

- Medicare claims are a significant source of data used in benchmarking
- CMS often links claims data from various provider types
- Process measures rely on provider reported data (subject to audit)


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Source of Performance Data

- CMS is distributing many hospital specific reports
 - Detailed risk adjustment reports by patient
 - Readmissions
 - MSPB
 - Trending reports
- Data often released on portals for data reporting (e.g. QualityNet)


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Data Collection Periods

- Varies significantly between programs
- Common methodology
 - Performance Period: two years before rate year
 - Baseline Period: four years before rate year
- Length of period
 - Often one year of data
 - Sometimes two or three years of data


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Risk adjustments

- All measures are risk-adjusted to some extent
- Often dozens of risk factors
 - DRG
 - Patient Age
 - Diagnoses
 - ICU


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Hospital-Acquired Conditions

- HACs new penalty in FFY 2015
- Composite score from three sources of infection tracking
 - Composite Medicare safety indicators
 - PSI-90: pressure ulcer rate, post-op hip fracture, post-op sepsis, accidental puncture/laceration
 - Present on admission indicators N/U
 - Two types of National Healthcare Safety Network (NHSN) CDC hospital-acquired infection measures (Medicare and non-Medicare)


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Hospital-Acquired Conditions

- 1% reduction in payment for hospitals in the top quartile. This is an all-or-nothing penalty.
 - “99 percent of the amount of payment that would otherwise apply.”
- Reduction applies to add-on payments such as outliers, DSH, uncompensated care, and IME


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Hospital-Acquired Conditions

- Domain 1 – AHRQ Patient Safety Indicators (PSI)
- Domain 2 Measures
 - FFY 2015
 - Central line-associated blood stream infection
 - Catheter-associated urinary tract infection
 - FFY 2016
 - FFY 2015 measures, and
 - Colon surgery surgical site infection
 - Abdominal hysterectomy surgical site infection
 - FFY 2017
 - FFY 2016 measures, and
 - MRSA infection rate
 - C. Diff infection rate


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Hospital-Acquired Conditions

- For CDC hospital-acquired infections, sample size matters
 - Score based on performance relative to predicted number of infections (risk-adjusted)
 - For 12-month period, if only 10 infections projected, impact of a few infections:
 - 0 infections: 100th percentile (higher is better)
 - 4 infections: ~60th percentile
 - 10 infections: ~39th percentile


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Hospital Readmission Reduction Program

- Providers with high numbers of readmissions in targeted areas will have reduced reimbursement
 - Max of 1% in FFY 2013, 2% in FFY 2014 and 3% in FFY 2015
 - “All Cause”, though risk-adjusted
 - Based on three-year rolling averages
 - Excess Readmission Ratio


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Hospital Readmission Reduction Program

- Targeted areas for FFY 2015
 - Heart attack (AMI)
 - Heart failure (HF)
 - Pneumonia (PN)
 - Total hip/knee arthroplasty (HK) (new)
 - Chronic obstructive pulmonary disease (COPD) (new)


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Hospital Readmission Reduction Program

- For FFY 2017, new measure: Coronary Artery Bypass Graft (CABG)
 - Annual cost of readmissions: \$151 million
 - Isolated CABG procedures only. Patients with other cardiac procedures in same encounter are excluded.
 - Unlike other measures, CABG readmission methodology includes cases transferred to acute care hospital after procedure.
 - Presumption is that provider who is transferring the case will be “encouraged by this measure to work closely with the institutions they transfer patients to, to provide optimal continuity of care for their patients”

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Effect of Hospital Mix on Penalty

Readmission Target	Excess Readmission Ratio	Hospital A IPPS Operating Payments	Hospital A Excessive Payments	Hospital B IPPS Operating Payments	Hospital B Excessive Payments
AMI	1.08	\$6,000,000	\$480,000	\$80,000	\$6,400
HF	0.99	\$6,500,000	\$0	\$800,000	\$0
PN	1.12	\$3,500,000	\$420,000	\$600,000	\$72,000
Others		\$135,000,000		\$18,000,000	
Total		\$151,000,000	\$900,000	\$19,480,000	\$78,400
Excess Pay as % Total			0.596%		0.402%

Although both hospitals have the same excess readmission ratios, the mix of services ultimately determines the percentage of excess payments (and therefore the readmission penalty).


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Hospital Readmission Reduction Program

- Planned Readmission Algorithm
 - Identifies procedures that are always considered planned (and therefore not an unplanned readmission)
 - Identified primary discharge diagnoses that are always planned
 - Procedures considered planned unless accompanied by an acute (or unplanned) primary diagnosis
 - For example, ongoing treatments such as maintenance chemotherapy for cancer or cardiac device placement for cardiovascular disease patients are excluded from the calculation
 - Clinical Classification Software (CCS) used


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Hospital Value-Based Purchasing

- Reimbursement impact
 - Revenue-neutral program for CMS
 - All hospitals will see a reduction in the operating payment, then add back based on performance
 - 1.5% for FFY 2015
 - 1.75% in FFY 2016
 - 2% in FFY 2017 and beyond. CMS has no plans to increase financial impact.

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Hospital Value-Based Purchasing

	FFY 2013	FFY 2014	FFY 2015	FFY 2016
Clinical Process of Care	70%	45%	20%	10%
Patient Experience of Care	30%	30%	30%	25%
Outcomes		25%	30%	40%
Efficiency			20%	25%

CMS believes “that domains need not be given equal weight, and that over time, scoring methodologies should be weighted more towards outcomes, patient experience of care, and functional status measures (for example, measures assessing physical and mental capacity, capability, well-being and improvement).”

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Hospital Value-Based Purchasing

- In FFY 2017 domains will change in order to align with the National Quality Strategy. No significant change to components in measure.

National Quality Strategy	Current VBP
Safety	Outcomes
Patient and Caregiver experience and outcomes	Patient Experience of Care / Outcomes
Care coordination	Efficiency
Clinical Care	Clinical Process of Care
Population Health	Outcomes
Efficiency and Cost Reduction	Efficiency

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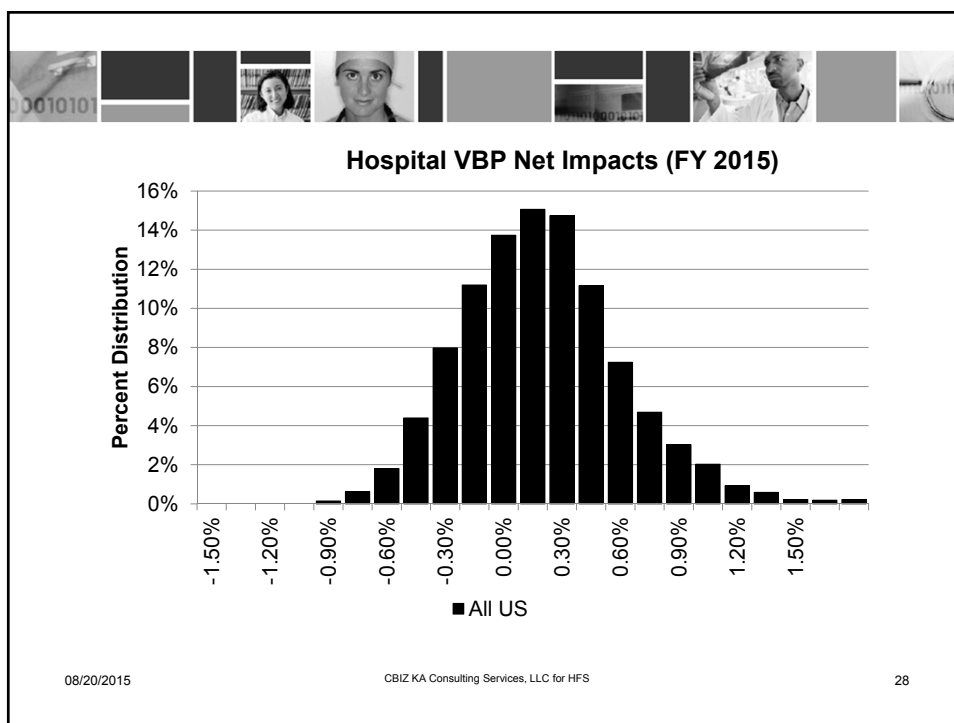
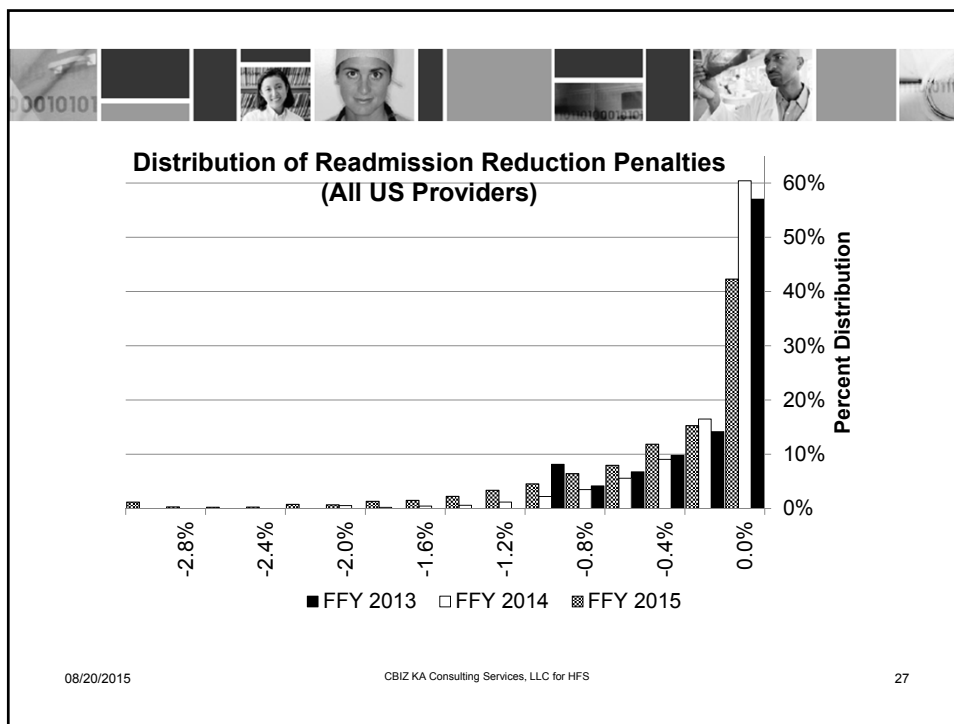


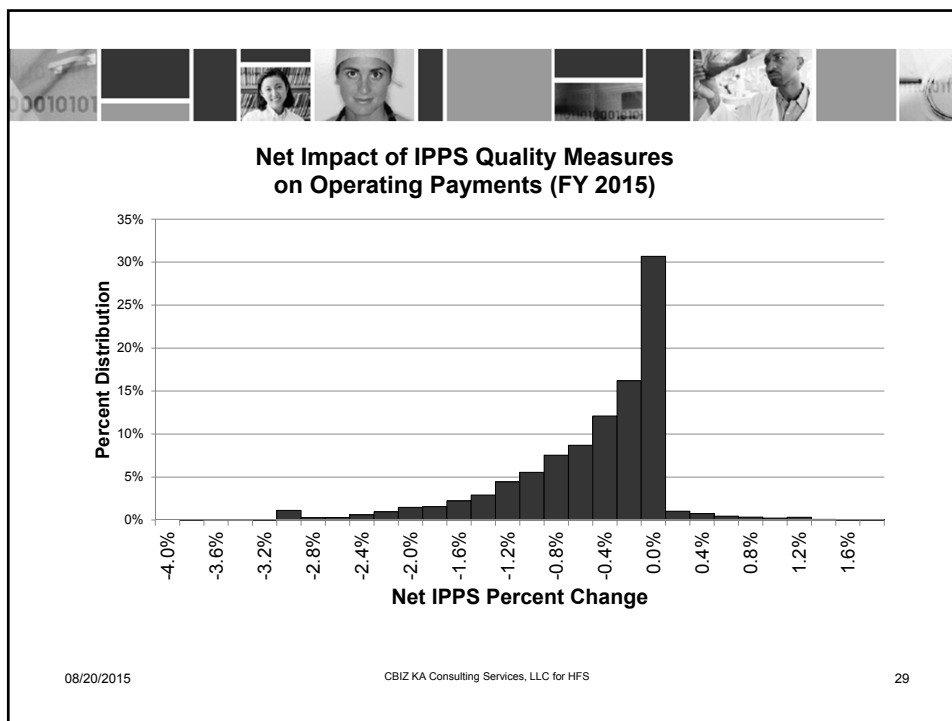
Hospital Value-Based Purchasing

- Realignment of Measures

	FFY 2017	Measures
Safety	20%	CAUTI, CLABSI, <i>C. difficile</i> , MRSA, PSI-90, SSI (All were in Outcomes Measure)
Clinical Care – Outcomes	25%	Mortality (AMI, HF, PN)
Clinical Care – Processes	5%	AMI-7a, IMM-2, PC-01
Efficiency and cost reduction	25%	MSPB
Patient experience	25%	HCAHPS

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ESRD Quality Incentive Program

- Program began in 2012
 - Maximum 2% penalty
 - Applies improvement / achievement methodology
 - For 2016
 - 11 clinical measures, 3 reporting measures
 - CAHPS and Readmissions to be included in 2018 in shift to National Quality Strategy


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ESRD Quality Incentive Program

- Time periods
 - Comparison Period: designated time during which data is gathered on all dialysis facilities. This is the time period used to create performance standards
 - Performance period: follows the comparison period. An individual provider's scores in the performance period will be compared to standards from the comparison period.
 - Example for program year 2016
 - Period of performance is CY 2014
 - Performance period is 2 years
 - CY 2012 for achievement
 - CY 2013 for improvement


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SNF Value-Based Purchasing

- Mandated by Protecting Access to Medicare Act of 2014
 - 2% withhold; add-back methodology not finalized
 - 30 – 50% of withhold to be applied to “Medicare Savings”
 - One measure – Readmissions
 - 23.5% of SNF readmissions result in re-hospitalization
 - 78% avoidable; cost of \$3.39 billion


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SNF Value-Based Purchasing

- SNF 30-Day All-Cause Readmission Measure
 - Designed to access failed transitions from an acute care hospital to SNF
 - “Prior proximal hospitalization” Acute IPPS Hospital, CAH, or psych hospital
 - Risk-adjusted
 - Excludes 30-day episodes with IRF or LTCH visit; episodes with multiple SNF encounters, cancer, planned readmissions


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Home Health Value-Based Purchasing

- Data collection proposed to begin CY 2016
- No financial impact until 2018
 - 5% funding pool 2018/2019
 - 6% in 2020
 - 8% in 2021 forward
- Only one state for each of nine geographical groupings
 - Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington

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Home Health Value-Based Purchasing


- Two cohorts for each state
 - Large / small
- Applies achievement / improvement methodology
- Initial measures include
 - Outcomes from OASIS
 - CAHPS
 - Process measures
 - Claims measures (e.g. hospitalization rates)
- VBP Points for reporting on new measures

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**TABLE 26: HHA Cohort Payment Adjustment Distributions by State
(based on a 5 percent payment adjustment)**

Smaller-volume HHA Cohort by State											
State	# of HHAs	Average payment adjustment	10%	20%	30%	40%	50%	60%	70%	80%	90%
AZ	31	0.64%	-3.33	-2.72	-2.17	-0.82	0.56	1.31	3.36	4.75	5.00
FL	353	0.44%	-3.01	-1.76	-1.00	-0.39	0.21	0.94	1.84	3.04	4.38
IA	23	0.17%	-3.14	-2.53	-2.01	-1.41	-0.97	0.31	2.74	3.25	5.00
MA	29	0.39%	-3.68	-1.75	-0.70	-0.10	0.39	0.79	1.33	2.46	4.68
MD	2	-0.47%	-2.71	-2.71	-2.71	-2.71	-0.47	1.78	1.78	1.78	1.78
NC	9	0.72%	-2.38	-1.84	-1.41	-1.23	-0.68	0.34	3.67	5.00	5.00
NE	16	-0.51%	-2.26	-1.80	-1.64	-1.43	-1.13	-0.44	0.40	0.42	1.46
TN	2	2.48%	-0.05	-0.05	-0.05	-0.05	2.48	5.00	5.00	5.00	5.00
WA	1	0.00%	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Larger-volume HHA Cohort by State											
State	# of HHAs	Average payment adjustment	10%	20%	30%	40%	50%	60%	70%	80%	90%
AZ	82	0.39%	-3.31	-2.75	-2.19	-0.81	0.56	1.31	3.38	4.75	5.00
FL	672	0.41%	-3.00	-1.75	-1.60	-0.38	0.19	0.94	1.81	3.06	4.38
IA	129	-0.31%	-3.13	-2.31	-2.70	-1.13	-0.56	0.13	0.56	1.19	3.50
MA	101	0.64%	-2.88	-2.19	-1.50	-0.38	0.63	1.25	2.06	3.81	4.88
MD	50	0.41%	-2.75	-2.06	-2.30	-0.88	0.00	0.81	2.38	2.94	4.13
NC	163	0.65%	-2.75	-1.56	-1.30	-0.06	0.38	0.94	1.88	3.06	4.88
NE	48	0.37%	-2.63	-2.19	-1.40	-0.56	-0.19	0.50	1.31	2.31	5.00
TN	134	0.39%	-2.56	-1.81	-2.00	-0.63	-0.06	0.81	1.44	2.50	4.69
WA	55	0.39%	-2.75	-1.63	-2.00	-0.94	-0.19	0.69	1.94	3.31	4.06


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Physician Value-Based Modifier

- Began in 2015 to Groups of 100+ Eligible Professionals
 - Expanding in 2016 to groups of 10+ Eps
 - 2017 applies to nearly all EPs
- Revenue neutral to CMS
- Two categories of measurement
 - Quality
 - Cost
- Attribution based on primary care


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Physician Value-Based Modifier

- Includes a pay-for-reporting provision
- Two categories of measurement
 - Quality
 - Hospitalization rates for acute conditions
 - Hospitalization rates for chronic conditions
 - Hospital readmission rates
 - Cost
 - Per capita costs per beneficiary per year
 - MSPB per episode

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Physician Value-Based Modifier

Table 1: Distribution Using 2013 Data of Quality and Cost Tiers for 106 Physician Groups with 100 or More Eligible Professionals that Elected Quality-Tiering and had Sufficient Data to Calculate a Cost and Quality Composite

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0% (0)	+1.0x = 4.89% ² (2)	+2.0x = 9.78% ² (0)
Average Cost	-0.5% (7)	+0.0% (81)	+1.0x = 4.89% ² (12)
High Cost	-1.0% (3)	-0.5% (1)	+0.0% (0)


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Physician Value-Based Modifier

- 2016 Changes
 - 10+ EP Groups must participate in PQRS to avoid -2% reporting penalty
 - At least 50% of EPs in the group must report data
 - Low Quality / High Cost groups subject to 2% penalty

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Physician Value-Based Modifier


- Medicare and CHIP Reauthorization Act (MACRA) of 2015
- Significantly changes the program in 2019
 - Providers NOT in a Medicare ACO will be subject to Merit-Based Incentive Payment System (MIPS)
 - Blend of Physician Value-Based Modifier, EHR Meaningful Use, and PQRS reporting
 - Providers in Medicare ACOs are exempt from quality adjustment
- Details to be finalized in rule making

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New Developments in Quality Based Reimbursement


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Socioeconomic Status

- Many comments to CMS about the lack of socioeconomic status (SES) [or sociodemographic status (SDS)]
- CMS has continued to push back against comments that SES makes a significant difference with risk scoring


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CMS comments on socioeconomic factors (2013)

– “Our analyses also show that adding socioeconomic status to the risk-adjustment has a negligible impact on hospitals’ risk-standardized [readmission] rates. The risk-adjustment for clinical factors likely captures much of the variation due to socioeconomic status, therefore leading to more modest impact of socioeconomic status on hospitals’ results than stakeholders expect.”

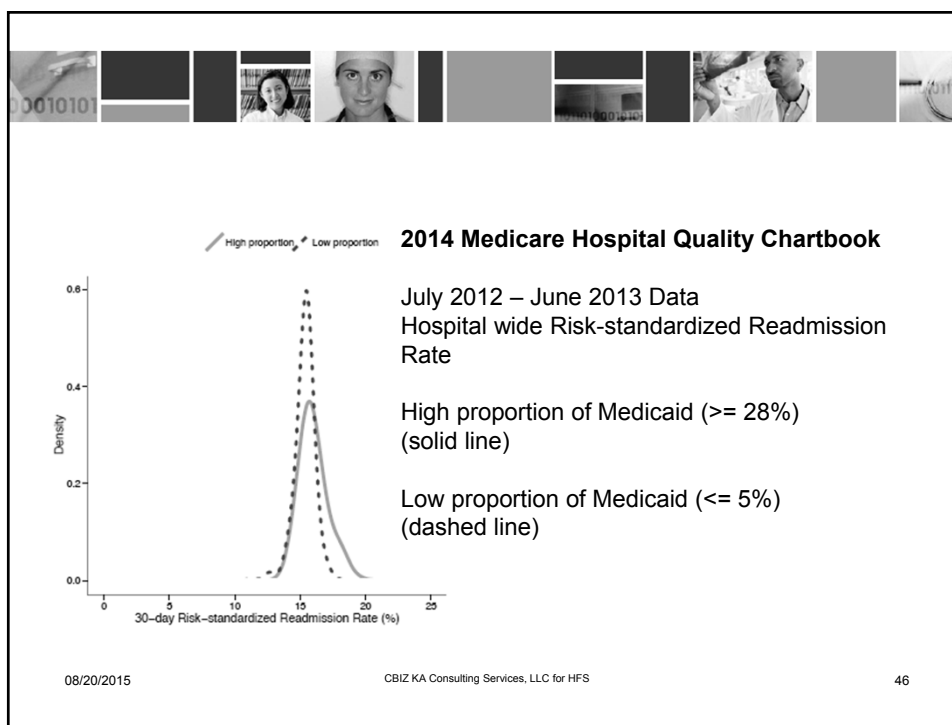
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Socioeconomic Status

- CMS standard response on SES adjustment
- “[W]e continue to have concerns about holding hospitals to different standards for the outcomes of their patients of low sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of sociodemographic status on hospitals’ results on our measures. To date, we have found that hospitals that care for large proportions of patients of low sociodemographic status are capable of performing well on our measures...” (FY 2016 IPPS Final Rule)

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Socioeconomic Status

- CMS is “committed to working with NQF and other stakeholder communities to continuously refine our measures and to address the concerns associated with SES and risk adjustment.”


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Socioeconomic Status

- National Quality Forum (NQF) Technical Report: “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors”
 - Released August 15, 2014
 - Important because NQF initiatives drive the data collection used by CMS for quality reporting


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Socioeconomic Status

- NQF sees measures used for accountability programs and pay-for-performance and responds:
 - “Getting the measures ‘right’ is important given that they are being used to determine which providers to include in networks, how to determine financial rewards or penalties, where to go for healthcare services, and where to focus improvement efforts.”


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Socioeconomic Status

- Some of the recommendations in the report
 - SES factors should be included in risk adjustment unless conceptual reason or empirical evidence to indicate such adjustment is inappropriate.
 - Transition period should include periods of reporting both SES-adjusted and unadjusted scores
 - Consensus Standards Approval Committee recommended, and the NQF Board of Directors approved, a trial period that lifts restrictions against SES adjustments
 - Created a Disparities Committee


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Socioeconomic Status

- From the NQF Report, traits of a sociodemographically challenged patient:
 - Poverty – Low income and/or no liquid assets
 - Low levels of formal education, literacy, or health literacy
 - Limited English proficiency
 - Minimal or no social support – not married, living alone, no help available for essential health-related tasks
 - Poor living conditions – homeless, no heat or air conditioning in home or apartment, unsanitary home environment, high risk of crime
 - No community resources – social support programs, public transportation, retail outlets


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Socioeconomic Status

- NQF has concerns that are similar to CMS'
 - "... if performance measurement fails to recognize sociodemographic complexity, then it may create a disincentive for healthcare providers and health plans to serve disadvantaged patients, decreasing access to healthcare..."
 - "... if performance measurement adjusts for sociodemographic factors, then it may create a disincentive for healthcare providers and plans to improve care to disadvantaged patients."


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Socioeconomic Status

- Where will SES data come from? Many unanswered questions.
 - Patient-specific?
 - Dual eligibility varies with Medicaid Expansion
 - Population-based?
 - Mortality and cancer incidence found to correlate better to Census Tracts than Zip Codes
 - Employment Status?
 - Stay-at-home parent or unemployed job seeker?


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Socioeconomic Status

- Where will SES data come from?
 - Race and Ethnicity
 - “Race and ethnicity are not and should not be used as proxies for SES”
 - Education / Literacy / Language
 - How to measure “Health Literacy?”
 - Patient Living Environment
 - Marital Status
 - Community/Family Support


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Socioeconomic Status

- Report on All-Cause Admissions and Readmissions Measures, April 2015
- NQF participants ranked adjustment for sociodemographic status (SDS) as the highest priority issue for readmission measures.
- All-Cause Admissions and Readmissions Standing Committee will re-evaluate for consideration of SDS adjustment


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IMPACT Act

- Improving Medicare Post-Acute Care Transformation Act of 2014
- Requires CMS to standardize data reporting between LTCH, IRF, SNF, & HHA providers across eight measures (with NQF)
 - Skin integrity, functional status, medication reconciliation, major falls, health information, resource use (MSPB), discharge patterns, hospital readmissions
- Goal is to compare similar post-acute encounters when possible


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IMPACT Act

- Requires HHS and MedPAC to study
 - links between payment and quality
 - beneficiary socioeconomic status on quality measures
 - Office of the Assistant Secretary for Planning and Evaluation
- Standardized reporting to start in FY 2017
- Data released to public in FY 2019

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Thank You!

- Questions?
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