I. Introduction

Evolution of Medicare as a Purchaser

• Cost reimbursement
  — rewards more services but capped at “reasonable costs”
• Prospective payment
  — Flat fee; incentives for efficiency but still rewards volume
• Pay for Performance (P4P) Gains Real Steam with the ACA
Affordable Care Act Quality Provisions

- **Pre-existing quality reporting programs (IQR/OQR) laid the foundation.**

- **Hospital Value-based purchasing program (ACA § 3001)**
  - Adds incentives for quality of services provided
  - Begins FFY 2013 with 1% reduction (increasing to 2% over 4 years) but can recoup reduction amount plus an incentive pymt

- **Hospital readmissions reduction program (ACA § 3025)**
  - Focuses on 30-day readmission rates for key diagnoses (HF, PN, AMI)
  - Begins FFY 2013 with up to 1% reduction increasing to 3% in FFY 2015

- **Healthcare acquired conditions (ACA § 3008)**
  - Begins FFY 2015; up to 1% reduction

- **6% of base DRG payments at risk by 2017**

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Down with P4P? Yeah You Know Me!

-A major, overarching theme in the Affordable Care Act is one of measurement, transparency, and altering payment to reinforce, not simply volume of services, but the quality of the effects of those services. Instead of payment that asks, “how much did you do,” the Affordable Care Act clearly moves us toward payment that asks, “How well did you do?” and, more important, “How well did the patient do?”

That idea is at the heart of Value-Based Purchasing. It is not just a CMS idea; it is one increasingly pervading the agenda of all payers.”

Don Berwick, CMS Administrator, April 4, 2011
Swap slides 3 & 4?
Author, 3/27/2014
Who Participates?

• Basically all “subsection (d) hospitals” (not IPPS excluded hospitals) participate in quality programs with certain few exceptions

II. Hospital Inpatient Quality Reporting (IQR) Program

• For 2016, adopting all of the IQR Program measures from 2015 except:
  — Removing seven measures (six chart-abstracted measures and 1 structural measure) and suspending one chart-abstracted measure.
  — Finalized five new claims-based measures
• In sum: CMS will collect quality data on a total of 57 measures (2 less than 2015)
• Penalty for failing to report -- strictly interpreted!
• Results publicly reported on the Hospital Compare Web site
Add slide listing categories of measures?
Author, 3/27/2014
III. Hospital Outpatient Quality Reporting (OQR) Program

• Modeled on the IQR program & mandated by the Tax Relief and Health Care Act of 2006.

• 2 percentage point reduction in annual payment update (APU) for failing to properly report

• Hospitals must submit data for 27 quality measures; these include clinical performance measures, imaging efficiency measures, and web-based (structural) measures.

• Focus on emergency department and outpatient surgical quality measures (e.g., administering the right kind of antibiotic before O/P surgery & aspirin for heart attacks at ER)

• Results publicly reported on the Hospital Compare Web site

• Outpatient imaging ($14 billion annually for Medicare beneficiaries). Focused on appropriate utilization, technical performance by certified personnel, timeliness in study reporting

IV. VBP -- Concept of Value-Based Purchasing Program

• Once IQR program in place, only a matter of time before $ tied to results reported on quality measures – ACA § 3001

• Set aside a pool from existing Medicare PPS dollars
  — Funded through reductions in base operating DRG per discharge payment reductions
    — 1% in FY2013 up to 2% in FY2017 forward
    — Over $1 billion per year redistributed

• Redistribute the pool among PPS hospitals based on their performance on certain quality measures
  — as compared to other hospitals
  — as compared to each hospital’s prior performance

• Create incentives to improve quality--race to the top
Elements of the VBP Program

- Four primary components
  - 1. The Performance Standards
  - 2. The Measures
  - 3. The Score
  - 4. The Payment

How Will Hospitals Be Evaluated?

**Improvement vs. Achievement**

- **Achievement:**
  - My hospital’s current performance compared to all hospitals’ Baseline Period Performance

- **Improvement:**
  - My hospital’s current performance compared to my Baseline Period Performance

Source: CMS
Threshold v. Benchmark

VBP Scoring

• Achievement:
  — 10 pts for meeting or exceeding the benchmark
  — 0 pts for performing below threshold
  — 1-9 on a linear scale between the threshold and benchmark

• Improvement
  — Similar formula to achievement score
  — 0 pts if below hospital’s own baseline score; 1-9 pts on a linear scale if above baseline score; 10 pts for meeting national benchmark
Sample VBP Score for Process Measure

Measure: AMI-7a-Fibrinolytic Therapy

Hospital A earns 6 points for achievement
Hospital A earns 7 points for improvement
Hospital A score = higher of achievement or improvement = 7 points

What Is Being Measured?

- Quality Measures divided into differently weighted buckets or “domains”
- Two domains for FFY 2013:
  - Process of Care (70%) and Patient Satisfaction (HCAHPS) (30%)
- Three domains for FFY 2014:
  - Process of Care (45%), HCAHPS (30%), Outcome measures (30-day mortality for AMI, HF, and PN) (25%)
- Four domains for FY 2015
  - Process of Care (20%), HCAHPS (30%), Outcome measures (now inc. Central Line-Associated Blood Stream Infection (CLASBI) and AHRQ PSI-90 Composite) (30%), and efficiency domain (MSB) (20%)
- Four domains for FY 2016
  - Process of Care (10%), HCAHPS (25%), Outcome measures (now inc. surgical site infection measure (SSI)) (40%), and efficiency domain (MSB) (25%)
VBP Timing - Performance Now Affects Payments starting Oct. 1, 2015

**Finalized Performance and Baseline Periods for the FY 2016 Hospital VBP Program—Clinical Process of Care, Patient Experience of Care, and Efficiency Domains**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
</table>

**Finalized FY 2016 Performance Periods and Baseline Periods for 30-Day Mortality and AHRQ PSI Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline period</th>
<th>Performance period</th>
</tr>
</thead>
</table>

“Compression” Problem

- Process measures standards—8 at 100%

### HCAHPS Scores

- Must report minimum of 100 surveys
- Eight dimensions are weighted equally
- Achievement - 0-10 points
- Improvement - 0-9 points
- Formulas are similar to process scores
- Can also achieve up to 20 points for “consistency”
- Total = sum larger of achievement or improvement for each measure + consistency score
A11 100% compliance is tough b/c not only exclusions captured.

Author, 3/27/2014
HCAHP Floor, Threshold and Benchmark Scores

**Outcome Domain**

- **Outcome Domain** (worth 45% of score in 2016)
  - Mortality measures: How many of a hospital’s HF, PN, and AMI patients are alive 30-days after admission?
    - “All cause” mortality
  - CLABSII: (Central Line-Associated Blood Stream Infection measure) which is an HAI measure that assesses the rate of bloodstream infection or clinical sepsis among ICU patients
  - AHRQ PSI composite measure (PSI-90) which is a composite measure of patient safety indicators developed and maintained by AHRQ.
  - Surgical Site Infection (SSI) Measure (colon and hysterectomy) (new for 2016)
Performance Standards for Outcome Measures

- Compression problem continues:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Achievement Threshold</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-day mortality rate</td>
<td>0.847742</td>
<td>0.862371</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-day mortality rate</td>
<td>0.961510</td>
<td>0.900315</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-day mortality rate</td>
<td>0.902951</td>
<td>0.904161</td>
</tr>
<tr>
<td>PSI-90</td>
<td>Complication/patient safety for selected indicators (composite)</td>
<td>0.622879</td>
<td>0.451792</td>
</tr>
</tbody>
</table>

“Efficiency Domain” = MSB

- Adopted new “efficiency” domain for 2015 with one measure: the Medicare Spending per Beneficiary (MSB).
  - MSB will include all Part A and Part B payments from 3 days prior to admission through 30 days post discharge with certain exclusions.
  - Risk adjusted for age and severity of illness, and payments are standardized to remove differences attributable to geographic payment adjustments and other payment factors (e.g., DSH).
  - Excludes high-cost outliers.
- Threshold, i.e., minimum score for a hospital to receive any achievement points for the measure, would be the “median [MSB] ratio across all hospitals during the performance period”
- Benchmark to receive full 10 points is spending per beneficiary in lowest 5% of hospitals nationally.
- Example: For May 15, 2010 – Feb. 14, 2011, median MSB was $17,988; benchmark $14,495.
Calculating Total VBP Score and Payment

• Will only use measures and domains that apply to the hospital

• Convert to percentage of total points available using weighted domains

• Linear Payment Exchange Function

Tips for Improving VBP Performance

• Know where your hospital stands on each selected measure for the baseline period and identify which measures have the best rate of return.
  
  — For example, if a hospital was at the benchmark for a compressed measure in its baseline period, then a slight percentage change in score on that measure for the performance period could cause the hospital to lose 10 points (if it drops below the compressed threshold)
  
  — On the other hand, it could take a very large percentage improvement to pick up less than 9 points, as an improvement score, on a measure where the hospital was well below the threshold for the benchmark period
  
  — In that scenario, it may make sense to play defense first, before devoting resources to improvement on the latter measure
Tips for Improving VBP Performance (cont.)

• Understand how discharge volume by measure factors into the VBP score
  — Each measure has an equal weight within a domain
  — An orthopedic hospital’s great performance on measures relevant to hundreds of surgical cases could, therefore, be offset by missing performance indicators in a handful of heart failure cases

IQR = VBP Crystal Ball?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Previously adopted hospital IQR Program measures and measures finalized in this final rule for the FY 2016 payment determination and subsequent years</th>
</tr>
</thead>
</table>
| Mortality Measures (Medicare Patients) | • Acute Myocardial Infarction (AMI) 30-day mortality rate.  
• Heart Failure (HF) 30-day mortality rate.
• Pneumonia (Pne) 30-day mortality rate.
• Stroke 30-day mortality rate.
• COPD 30-day mortality rate.*** |

**Patients’ Experience of Care Measures**

• HCAHPS survey (expanded to include one 3-item care transition set. * and two new “About You” items).*

**Readmission Measures (Medicare Patients)**

• Acute Myocardial Infarction (AMI) 30-day Risk Standardized Readmission Measure.
• Heart Failure (HF) 30-day Risk Standardized Readmission Measure.
• Pneumonia (Pne) 30-day Risk Standardized Readmission Measure.
• 30-day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty.*
• Hospital-Wide All-Cause Unplanned Readmission (HWR).*
• Stroke 30-day Risk Standardized Readmission.***
• COPD 30-day Risk Standardized Readmission.***

*** New for 2016 IQR
Review Stroke and COPD measures - Note they are both in mortality and readmission domains!

Author, 3/27/2014
V. Hospital Readmissions Reduction Program

• Overview:
  — Compare hospital’s risk-adj 30-day readmission rate for Acute Myocardial Infarction; Heart Failure; Pneumonia to national average.
  — Identified by specified ICD-9-CM codes listed as “principal discharge diagnosis”
  — FY 2015, the policy will be expanded to four additional conditions (COPD, CABG, PTCA, Other Vascular)
  — Concept of Penalty Formula: What percentage of total payments were for “excess” readmissions for HF, PN, & AMI? We’re going to reduce your payments by that same percent (subject to a cap).

Concept

• “Base operating DRG payments” to “applicable hospitals” whose readmission rates for “applicable conditions” exceed risk-adjusted “expected” rates will be reduced (for all discharges) by up to 1 percent in FFY 2013.
  — Applies to Medicare FFS discharges occurring on or after October 1, 2012.
  — Reduction will be applied on a per-claim basis.
  — Maximum reduction increases to 3 percent in FFY 2015 and thereafter.
Concept (cont.)

- “Excess Readmission Ratio” Calculation
  - Risk-adjusted ratio of the number of “predicted” readmissions at the particular hospital as compared to the number of “expected” readmissions at an average hospital with similar patients.
  - If a hospital’s “Excess Readmission Ratio” is greater than 1, the hospital will lose some portion of its “base operating DRG payments” subject to a cap.

Hospital Readmissions Reduction Program

- Weak correlation b/w performance on VBP and readmissions: “More than 40% of hospitals that faced the maximum 1% penalty for readmissions earned bonuses for [VBP].” Modern Healthcare, 1/5/13
A14  Confirm how valid readmissions are handled. List of set expected readmissions?
Author, 3/27/2014
VI. Hospital-Acquired Condition (HAC) Reduction Program

- **Newest Member of the P4P family:** CMS recently finalized the last of the “pay for performance programs” mandated by the ACA, the hospital-acquired condition reduction program.

- Under the program, hospitals in the top 25% nationally for incidents of hospital-acquired conditions will have their PPS payments reduced by 1% beginning with 2015 discharges.

- “Applicable Hospital” (i.e., hospital penalized under HAC program)
  - Defined by statute as a “subsection (d) hospital . . . in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.”

- Amount of payment is determined after the application of the payment adjustment under the Hospital Readmissions Reduction Program and the VBP program.

HAC -- Measures and Domain

- Finalized 2 domains for the FY 2015 HAC program.
  - Domain 1, Agency for Healthcare Research and Quality’s (AHRQ) PSI-90 composite measure
  - Domain 2, two CDC chart-abstracted hospital acquired infection (HAI) measures

- Domain 1 weighted at 35% of the Total HAC score and Domain 2 at 65%.

- If a hospital’s Total HAC score is in the top 25% of nation, 1% payment cut.
HAC - Domain 1 Measures (AHRQ PSI)

<table>
<thead>
<tr>
<th>Proposed Approach:</th>
<th>Alternative Approach:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 individual measures (FY 2015 onward)</td>
<td>1 composite of 8 component indicators (FY 2015 onward)</td>
</tr>
<tr>
<td>PSI-3 (Pressure ulcer rate)</td>
<td>PSI-3 (Pressure ulcer rate)</td>
</tr>
<tr>
<td>PSI-5 (Foreign object left in body)</td>
<td>PSI-4 (Intestinal perforation rate)</td>
</tr>
<tr>
<td>PSI-6 (Iatrogenic pneumothorax rate)</td>
<td>PSI-7 (Central venous catheter-related blood stream infection rate)</td>
</tr>
<tr>
<td>PSI-10 (Postoperative physiologic and metabolic derangement rate)</td>
<td>PSI-8 (Postoperative hip fracture rate)</td>
</tr>
<tr>
<td>PSI-12 (Postoperative PE/DVT rate)</td>
<td>PSI-12 (Postoperative PE/DVT rate)</td>
</tr>
<tr>
<td>PSI-15 (Accidental puncture &amp; laceration rate)</td>
<td>PSI-14 (Wound dehiscence rate)</td>
</tr>
<tr>
<td></td>
<td>PSI-15 (Accidental puncture &amp; laceration rate)</td>
</tr>
</tbody>
</table>

Domain 1 (AHRQ) measures (cont’d)

- The AHRQ PSI measures are calculated using ICD-9 codes and, for the secondary diagnoses, the present on admission (POA) value associated with each secondary diagnosis in the claim is “N” or “U”.
- A POA value of “N” or “U” will incur penalty
  - “N” = Diagnosis was not present at time of inpatient admission
  - “U” = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- AHRQ measures take into consideration risk factors such as the patient’s age, gender, and comorbidities.
- AHRQ measures are claims based and capture occurrences of adverse events among claims for Medicare discharges only
Review significance of ICD-9; is it per condition?
Domain 2 CDC HAI (Hospital Acquired Infection) Measures

• The CDC HAI measures are chart-abstracted.  
• The CDC measures are calculated by dividing the total facility number of HAI events by the number of predicted HAI events.  
  — In predicting events, HAI measures account for risk factors, including patient location within the facility, medical school affiliation, and bed size of patient care unit.  
• Currently, CAUTI and CLABSI are ICU only. CMS “intend[s]” to eventually expand to non-ICU locations such as medical/surgical wards.

Domain 2: CDC HAI Measures Apply to Proposed Approach and Alternative Approach (Multiple FYs)

- Central Line-associated Blood Stream Infection (CLABSI) (FY 2015 onward)
- Catheter-associated Urinary Tract Infection (CAUTI) (FY 2015 onward)
- Surgical Site Infection (SSI):  
  - SSI Following Colon Surgery (FY 2016 onward)  
  - SSI Following Abdominal Hysterectomy (FY 2016 onward)
- Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (FY 2017 onward)  
- *Clostridium difficile* (FY 2017 onward)
Scoring

• For each measure, a hospital can receive between 0 (best) to 10 (worst) points.

• CMS had proposed not to award any points on a measure unless a hospital was in the top if adverse incident rate was within the highest 25% of hospitals nationally.

• Instead, finalized policy to award points based on what decile a hospital’s adverse incident rate falls into (e.g., 1 pt if hospital is in bottom 10% of adverse incidents for the measure but 10 pts if in the top decile of adverse incidents).

Scoring (cont’d)

• If a hospital only has sufficient measures in a single domain, its score will be based on that single domain.

• E.g., if a hospital does not have an ICU or if it has a predicted HAI of less than 1, its HAC score will based just on Domain 1, i.e., AHRQ PSI-90 composite measure.

• If a hospital’s Total HAC score is in the top 25% of nation, 1% cut to all Medicare payments.

• Note that CLABSI and PSI 90 measures are both also included in the 2016 VBP program (though for different time periods).
Applicable Period

• For FY 2015 HAC program, CMS will use the 24-month period from July 1, 2011 through June 30, 2013 for the AHRQ measures and calendar years 2012 and 2013 for the CDC measures.

Public Reporting

• The following information would be made public on the Hospital Compare Website: (1) the hospital’s score for each measure; (2) the hospital’s domain score; and (3) the hospital’s Total HAC Score.
VII. Conclusion

• Keep in Mind:
  — These are comparative measures! Don’t get left in the dust.
  — What are other hospitals doing?
  — Overlap in measures with other quality programs (AMI, HF, PN, PSI-90)
  — Importance of complete medical records and data extraction
  — Physician buy-in is KEY
  — Creating a “culture of quality” from top down

QUESTIONS?
Thank You

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