Medicare Hospital Payment Incentive Programs and Measures

NATIONAL QUALITY FORUM

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Medicare Hospital Payment Incentive Programs

- Overview of payment incentive programs
- Impact of programs and lessons for policymakers and hospitals
- Measures for payment incentives
- Measure development and selection
- Measurement issues and lessons for policymakers

What Is the National Quality Forum?

- Private, non-profit, membership organization
- Mission
  - Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
  - Endorsing national consensus standards for measuring and publicly reporting on performance; and
  - Promoting the attainment of national goals through education and outreach programs.
- Roles
  - Standard setting organization
  - Neutral convener

Medicare Hospital Payment Incentive Programs

Progressive Incentives to Promote Accountability and Reward Performance

Medicare Hospital Pay for Reporting Programs

- Hospital Inpatient Quality Reporting Program
  - Information is reported on the Medicare Hospital Compare website
  - Hospitals that do not report quality data receive a 2.0% reduction in their annual Medicare payment update

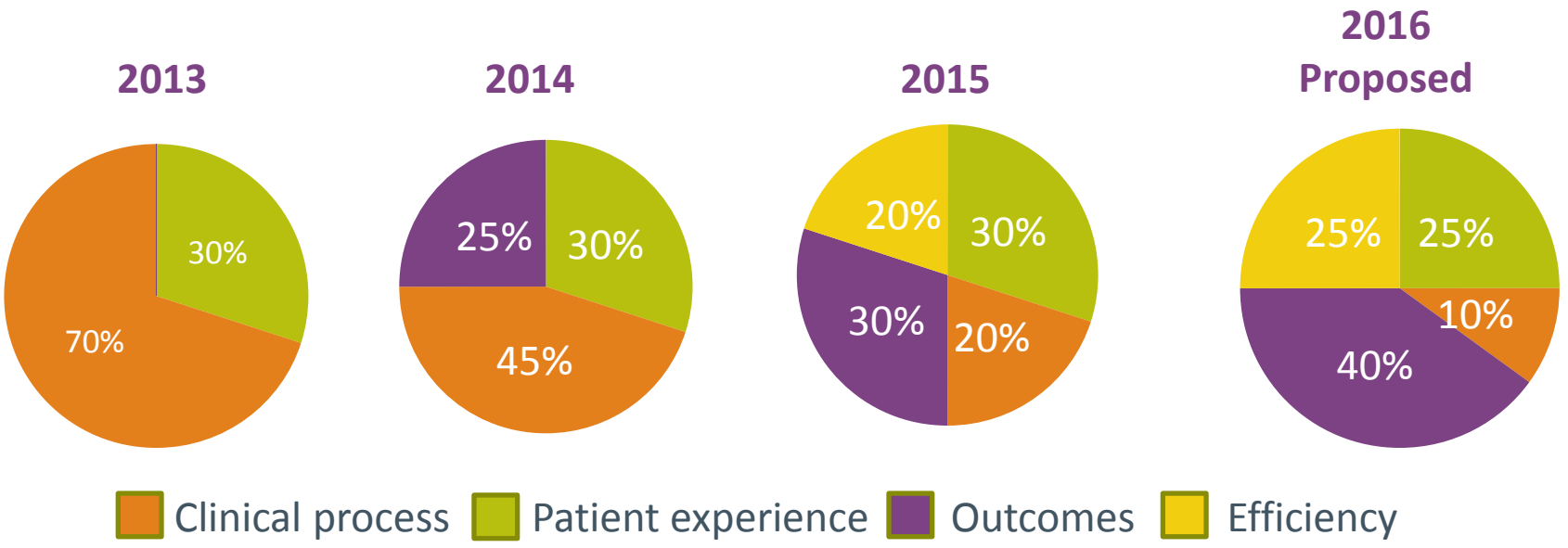
- Medicare has pay for reporting programs in other care settings, including:
  - Outpatient services, ambulatory surgery centers, cancer hospitals, inpatient psychiatric facilities, ambulatory care, nursing homes, home health, inpatient rehabilitation facilities, long-term acute care hospitals, dialysis facilities

Medicare Hospital Pay for "Meaningful Use" of Health Information Technology

- Purpose is to improve quality, safety, and efficiency through the promotion of health information technology, including electronic health records and health information exchanges
- Hospitals must adopt certified electronic health record technology and use it to achieve specific objectives, including reporting clinical quality measures
- Program provides incentive payments through 2015 and then payment penalties

Medicare Hospital Pay for Performance

Hospital Value-Based Purchasing Program



- Measures must be reported on Hospital Compare for a year prior to inclusion in the Hospital Value-Based Purchasing Program
- Eventually up to 2% incentive for attainment and/or improvement

Medicare Hospital Payment Penalties for Underperformance

- Hospital Readmission Reduction Program
  - 30 day readmission measures
    - » Current measures address acute myocardial infarction, heart failure, and pneumonia
    - » Proposed measures address chronic obstructive pulmonary disease and hip/knee replacement
    - » Exclusions for planned readmissions, including obstetrical delivery, transplant surgery, maintenance chemotherapy, and rehabilitation
  - Eventually up to 3.0% penalty for excess readmissions relative to other hospitals

Medicare Hospital Payment Penalties for Underperformance

- Hospital Acquired-Conditions
  - Began with non-payment for complicated DRG rate
  - New Payment Reduction Program
    - » Proposed measures address conditions such as pressure ulcers, foreign objects retained after surgery, and hospital-acquired infections including central line and urinary catheter
    - » 1.0% penalty for worst performing quartile

Impact of Hospital Payment Incentive Programs

- Programs are still in early stages; results are limited, mixed, and inconclusive
- As intended, payment incentive programs have brought attention to quality generally and focus on priority quality issues
  - Leadership investing in quality improvement
  - Moderate improvement on specific measures, but multiple interventions are occurring simultaneously

Potential Unintended Effects of Hospital Payment Incentive Programs

- Shifting resources away from facilities serving vulnerable populations—redistributive effects
- Creating access issues resulting from adverse selection
- Managing to measures, rather than providing evidence-based care
  - Pulling focus away from other priorities to earn incentive payments
  - Overuse or inappropriate care—antibiotic overuse
  - Readmission reduction may result in higher mortality
- Gaming measures through inaccurate documentation and coding
- Suppressing intrinsic motivation of professionals
- Undermining sharing of best practices
- Confusing the quality signal with overlapping incentives among programs

Key Lessons for Policymakers

- Incentives must be large enough to overcome inertia and counterincentives
- Public reporting and payment—transparency as part of accountability
- Reward both performance and improvement to avoid leaving poor performers behind
- Bonus versus penalty
- Monitoring and evaluation for unintended consequences
- Provide support for performance improvement
- Beware of administrative costs, including data collection and validation burden
- Global payments for integrated care models could address some issues raised by DRG-based incentives
  - Focus on health outcomes, rather than health care processes
  - System-level incentives to reduce total cost of care

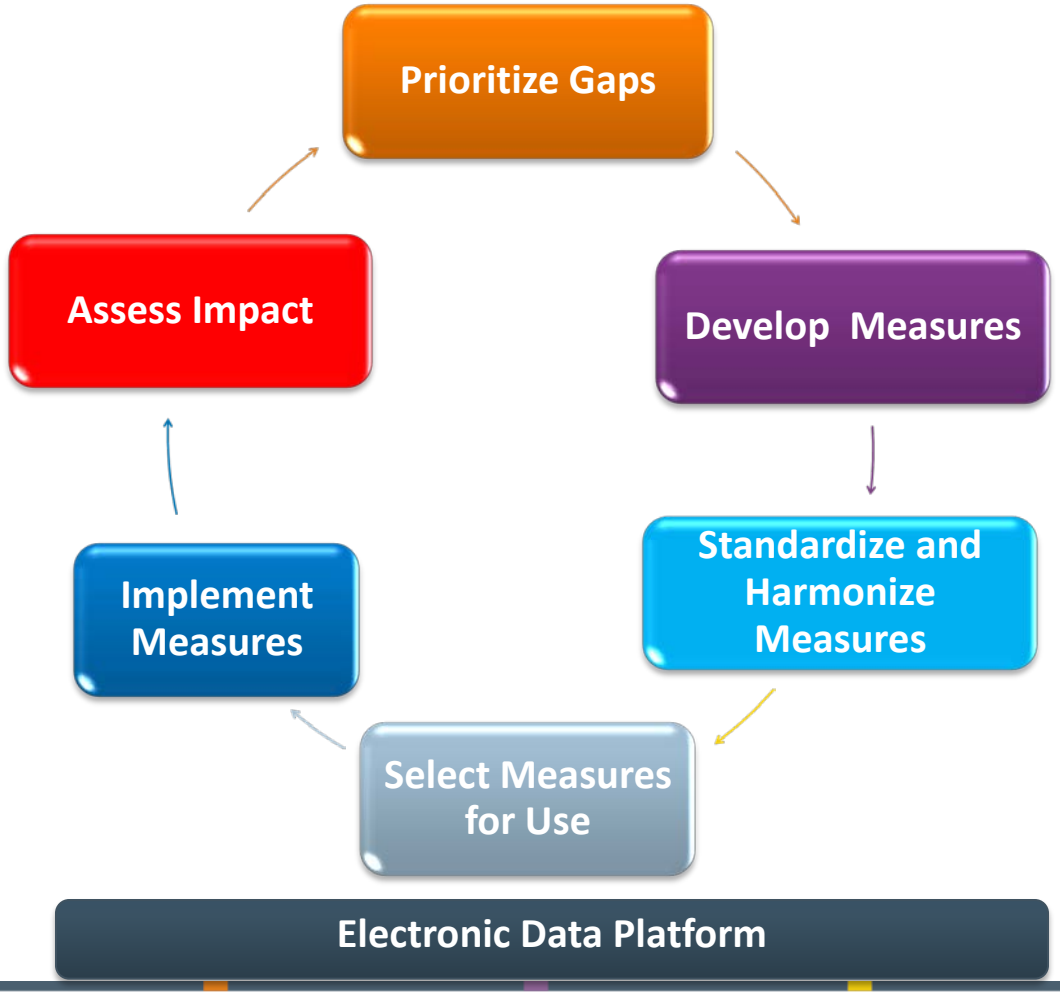
Key Lessons for Hospitals

- Establish and oversee system-level aims at the highest governance and leadership levels
- Develop and execute strategy to achieve aims
- Engage physicians
- Leverage information technology
- Develop a culture of quality
  - Transparency for accountability
  - Standardize measurement
  - Benchmark against peers
  - Workforce training and tools for improvement

Measures for Hospital Payment Incentive Programs

	Inpatient Quality Reporting / Hospital Compare	Hospital Value-Based Purchasing
Clinical Quality	Conditions: • Cardiovascular (AMI, HF, Stroke) • Pneumonia • Prevention/Immunization • Safety (Composite, Death, Surgical Complications, Venous Thromboembolism) • Perinatal Care	Conditions: • Cardiovascular (AMI, HF) • Pneumonia • Prevention/Immunization • Safety (Composite)
	HAC/HAI: • CLABSI,CAUTI, SSI, MRSA, C. difficile • Healthcare Personnel Influenza Vaccination	HAC/HAI: • CLABSI, CAUTI, SSI
	Surgical Care Improvement Project (SCIP)	Surgical Care Improvement Project (SCIP)
	Mortality (AMI, HF, Pneumonia)	Mortality (AMI, HF, Pneumonia)
	Readmissions: • Condition-Specific (AMI, HF, Pneumonia, THA/TKA) • Hospital-Wide	
	Emergency Department Throughput	
Patient Experience	HCAHPS (includes CTM-3)	HCAHPS
Cost	Medicare Spending per Beneficiary AMI Episode of Care	Medicare Spending per Beneficiary
Structure	Registry Participation (Cardiac Surgery, Stroke, Nursing Sensitive, Surgery)	

Measure Lifecycle



NQF Measure Endorsement Criteria

- **Importance to measure and report**
  - What is the level of evidence for the measure?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is the reliability and validity of the measure?
- **Usability**
  - What is the extent to which potential audiences (e.g., consumers, purchasers, payers, providers, policymakers) are using or could use performance results for both accountability and performance improvement?
- **Feasibility**
  - Can the measure be implemented without undue burden, captured with electronic data/EHRs?
- **Assess competing and related measures**

NQF Measure Selection Criteria

1. Measures within the program measure set are NQF-endorsed or meet the requirements for expedited review

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

NQF Measure Selection Criteria

5. Program measure set includes an appropriate mix of measure types

6. Program measure set enables measurement across the person-centered episode of care

7. Program measure set includes considerations for healthcare disparities

8. Program measure set promotes parsimony

Measurement Issues for Hospital Payment Incentive Programs

- Use measures that matter; avoid diluting incentives with:
  - Structure and process measures not related to outcomes, such as measures of documentation, screening, or general standard of care
  - Measures where the evidence base is absent or changing
  - Measures that have consistently high performance and lack discrimination
- Consider stratifying by race, ethnicity, and socioeconomic status to enable fair comparisons without adjusting away meaningful differences

Measurement Issues for Hospital Payment Incentive Programs

- Data collection burden can lead to measurement fatigue
- Clinical data is preferable to claims data for hospital-acquired conditions measures
  - While clinical data is more resource intensive to collect, health information technology can facilitate efficient data collection
- Reducing readmissions requires shared accountability and attribution across the continuum; not all readmissions are preventable
- Small numbers complicates measurement for events with low incidence or facilities with low patient volumes

Future of Measurement

- Future measure types
  - Outcome measures, including patient-reported
  - Cost/efficiency measures
  - Composite measures
  - eMeasures for electronic reporting

- Future measurement focus areas
  - Population health
  - Patient-centeredness

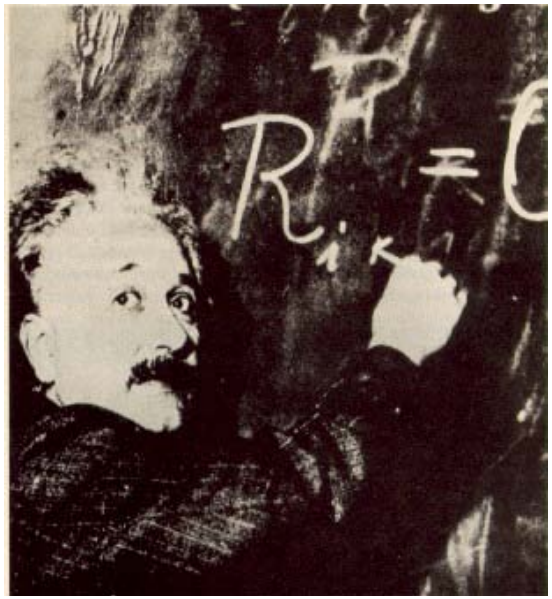
Key Lessons for Policymakers

- Promote progressive accountability through measurement tied to payment
- Consider fit for purpose to avoid measuring the wrong things
- Align measures to decrease burden and increase the quality signal
- Data sources are key—new data sources are required for innovative measures
- Monitor for fairness to providers and equity for patients

The Measurement Imperative

Not everything that counts can be counted, and not everything that can be counted counts.

~Albert Einstein



BUT…

You cannot improve what you do not measure.

Thank You

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