



American Hospital
Association®

Streamlining Quality Measurement and Pay-for-Performance

AHA View

America's hospitals are committed to sharing meaningful, accurate hospital quality information with the patients they serve. Hospitals also support well-designed pay-for-performance programs that can help move the health care delivery system from volume to value. However, the Hospital Readmissions Reduction Program (HRRP) and the Hospital Acquired Condition (HAC) Reduction Program must be reformed to ensure hospital penalties are assessed fairly. Moreover, Medicare and other federal programs must better align and prioritize measurement efforts to address the most important issues and promote more patient-centered, effective and efficient care.

Background

More than a decade ago, hospitals initiated voluntary efforts to report quality data publicly. This data reporting was later linked to receiving a full annual payment update from Medicare through the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs. The Affordable Care Act (ACA) significantly raised the financial stakes of quality measurement by introducing "pay-for-performance" programs – including the HRRP and HAC Reduction Program – that tie penalties to the level of quality performance. To date, however, HRRP penalties have disproportionately fallen on those hospitals caring for the poorest patients. Moreover, the HAC program disproportionately penalizes large and teaching hospitals caring for more complex patients and the smallest hospitals with too few patients for accurate assessment. Hospitals are overwhelmed by the sheer volume of measures they must report, and are concerned that important opportunities to improve care are being missed because the selected measures do not focus on issues that meaningfully improve care.

Key Priorities

The AHA continues to work with federal agencies, Congress and other stakeholders to help align quality reporting to improve health and health care. This includes:

- Improving the fairness of readmission penalties;
- Reforming the HAC Reduction Program; and
- Enhancing measurement alignment and focus.

Improving the Fairness of Readmission Penalties

The AHA strongly urges Congress and the Centers for Medicare & Medicaid Services (CMS) to incorporate socioeconomic adjustment into the HRRP so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized. We strongly support the bipartisan, bicameral Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688).

Since the HRRP's beginning, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In fiscal year (FY) 2015, nearly 85 percent of hospitals in the highest quartile of disproportionate patient percentage

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(DPP) received a penalty, compared to 61 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient’s health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on socioeconomic status, such as Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. If H.R. 1343/S. 688 is passed, CMS would be required to use these data to adjust penalties, providing important relief.

The AHA also urges CMS to exclude from the HRRP readmissions unrelated to the initial reason for admission. Despite the fact that the ACA requires CMS to exclude unrelated readmissions, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

Reforming the HAC Reduction Program

America’s hospitals are deeply committed to reducing preventable patient harm. However, the HAC Reduction Program is poorly designed and imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for the sickest patients. The AHA will work with CMS, Congress and others to improve existing policy and promote alternatives to the HAC program that more effectively promote patient safety.

The HAC Reduction Program has a number of critical flaws. First, the program’s arbitrary design penalizes 25 percent of all hospitals each year, regardless of significant performance improvement, and does not measure meaningful differences in quality. Indeed, the difference in HAC scores for penalized and non-penalized hospitals in FY 2015 is hundredths of a point. Second, data show that hospitals treating complex patients are disproportionately penalized, in part because the HAC program uses claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details of a patient’s risk factors and course of care. We have urged CMS to remove PSIs gradually from the HAC program. Third, some small hospitals have too few patients to have data on the two infection measures used in this program. These hospitals are assessed only on the unreliable PSIs. Finally, the HAC measures overlap with the measures in the value-based purchasing (VBP) program, yet each program uses different performance periods. This can lead to excessive payment penalties and confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that CMS use measures in either the VBP or the HAC program, but not in both.

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Enhancing Measurement Alignment and Focus

The AHA continues to advocate that CMS work with multiple stakeholders to identify between five and 10 tightly-scoped, actionable priority goals for health care quality improvement on an annual basis. CMS could then select for each of its quality measurement programs a small number of reliable, accurate and care-setting-appropriate measures to ensure each relevant part of the health care system contributes to the overall goals. We believe a more focused approach will lead to even more substantial improvements in care, as has been demonstrated through the success of the AHA's work on the targeted areas of the Hospital Engagement Network that saved an estimated 92,000 instances of harm and \$988 million.

To date, measurement requirements have been added without strong alignment to specific national quality priorities or goals. To add to the confusion, private payers and state regulators have adopted their own reporting requirements. As a result, the volume of measures requested of hospitals has grown so rapidly that it has created confusion about what is being measured, how it should be measured, and what the results of the measurement effort show. Hospitals spend significant resources making sense of reporting requirements that could instead be used on improving care.

To provide a starting point for identifying priorities, the AHA worked with its members to develop a list of 11 measurement concepts that hospitals believe are the highest priority to address. This list addresses multiple aspects of quality and includes issues like harm rates, patient transitions in care, risk-adjusted mortality and cost per episode. We will continue to work with all interested stakeholders to refine and encourage implementation of this focused set of measures.