Linking Quality to Payment

Our nation’s health care delivery system is undergoing a major transformation as reimbursement moves from a volume-based methodology to one based on value and quality. By linking hospital reimbursement to achieving positive outcomes on quality measures, the field can better align the health care delivery system toward continuous quality improvement, and provide financial rewards to providers that improve performance.

At the federal level, public reporting of quality measures was initially linked to reimbursement through the Inpatient Quality Reporting program (IQR). Authorized by the 2003 Medicare Modernization Act (MMA) and the 2005 Deficit Reduction Act (DRA), this “pay-for-reporting” program requires hospitals to report on quality measures in order to receive annual payment updates.

The Patient Protection and Affordable Care Act (ACA) significantly raised the financial stakes by creating several “pay-for-performance” programs that reduce Medicare reimbursement to hospitals that score below national performance benchmarks on selected quality measures. Some of the areas measured include readmissions, mortality, patient experience of care, and clinical process measures of heart attack, heart failure and pneumonia care.

AHA View

The AHA supports the general concept of linking hospital payments to meeting performance targets on quality measures. However, we are very concerned that many of the quality measures upon which federal pay-for-performance programs are based do not produce accurate performance results, making them inappropriate to use for public reporting and accountability programs. Moreover, we believe the manner in which some of the payment penalties are calculated lack fairness and equity. To ensure federal pay-for-performance programs realize their potential, the AHA’s efforts are focused on several fronts:

Value-based Purchasing (VB). Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program applies to inpatient prospective payment system (PPS) hospitals, with certain exceptions. It is budget neutral but is estimated to redistribute up to $963 million among hospitals in FY 2013.

The VBP program is funded by reducing all inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) operating payments to participating hospitals by 1 percent in FY 2013, which is then redistributed. This payment reduction gradually increases each year, topping out at 2 percent in FY 2017 and beyond.

Calculating the VBP score. Measures must be reported in the hospital IQR for at least one year before they are included in VBP. In FY 2013, the VBP program included 12 clinical quality measures as well as the Hospital Consumer Assessment
of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey. The clinical measures account for 70 percent of a hospital’s VBP score and the HCAHPS survey for 30 percent. The Centers for Medicare & Medicaid Services (CMS) also established “baseline” and “performance” periods for the measures. The agency evaluates each hospital’s scores in the performance period relative to both its baseline period score (i.e., “improvement score”), and to national scores during the performance period (i.e., “achievement score”). Hospitals receive the higher of an “achievement” or “improvement” score for each measure. Individual measures are assigned to one of several “domains” – including process, outcomes, patient experience and efficiency – that have a percentage weight used to calculate the hospital’s total performance score. The total score is used to determine the amount of incentive payment each hospital receives.

The AHA supports the concept of pay-for-performance programs that provide incentives for both demonstrated excellence and noteworthy improvements in patient safety and effectiveness. However, some of the measures selected for use in VBP are deeply flawed, and do not accurately reflect hospital performance. The AHA has expressed particular concern about the following:

- **Reliability of 30-day Mortality and Patient Safety Indicator measures:** Adequate measure reliability ensures that differences in performance scores across hospitals are, in fact, due to underlying differences in quality and not just random variations in patient populations. CMS has included three 30-day mortality measures in this domain for FY 2014. In FY 2015, it will add a claims-based Patient Safety Indicator (PSI). We have urged CMS to remove both the mortality and PSI measures from VBP until they demonstrate an adequate level of reliability. A CMS-commissioned analysis completed in February 2012, showed that both the mortality measures and PSI measure fall well short of the reliability level required of chart-abstracted measures in other programs. Even with two years of data, CMS’s analysis showed that the mortality measures could not meet the “lower limit of moderate reliability.”

- **HCAHPS measures:** We believe CMS should assign a lesser weight to scores from the HCAHPS survey. Emerging research suggests that HCAHPS scores may be impacted by the severity of patient illness more than previously thought. For example, research from the Cleveland Clinic has shown that as patient severity of illness worsens, their HCAHPS scores show a statistically significant decline. The current measures do not fully adjust for this phenomenon, meaning that hospitals may face an unfair, systematic disadvantage in VBP if they care for many severely ill patients.

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The AHA expects that CMS will continue to propose additional measures for use in VBP over the next several years, and may retire or suspend some that have already been adopted once performance on those measures has reached a level that suggests further improvement is unlikely. The AHA will continue to work with CMS to ensure that the measures selected for use in the hospital VBP are evidence-based, reliable and valid, and are important in improving patient outcomes and efficiency.

**Hospital Readmission Reduction Program (HRRP).** The HRRP imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. The penalty program began on Oct. 1, 2012, and can reduce hospital base Medicare payments by up to 1 percent in FY 2013. The potential penalty increases to 2 percent of base payments in FY 2014, and 3 percent in FY 2015 and beyond. The initial payment penalties are based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare IQR. The AHA is concerned about both the readmission measures used in the HRRP, and the manner in which the payment penalty is calculated.

The current readmission measures do not adequately adjust for socioeconomic factors. All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. Applying an appropriate adjustment for socioeconomic factors would acknowledge the reality that hospitals cannot always control or change structural barriers to accessing resources that can help prevent readmissions. In some cases, these barriers relate to an incomplete health care infrastructure in those communities. For example, a lack of access to primary care, mental health services, physical therapy and other rehabilitative support can affect readmissions. Other factors can include lack of transportation (which can affect access to medical care), and inconsistent access to nutritious foods. Given the financial impact of the HRRP, we remain concerned that without an adjustment for socioeconomic factors, resources will be taken away from hospitals caring for patients facing the most challenging circumstances. In recognition of these concerns, the Medicare Payment Advisory Commission (MedPAC) intends to further explore the role socioeconomic factors play in readmissions.

The measures also do not distinguish between related and unrelated readmissions, in spite of the ACA requirement that unrelated readmissions be excluded from measures used in the HRRP. The AHA successfully advocated for a provision in the law stipulating that readmissions that are unrelated to the original reasons for hospitalization or are planned should be excluded from the calculations of the measures. This distinction is important because it recognizes differences among patients served. CMS has made positive adjustments to these measures to exclude planned readmissions. Disappointingly, the agency has yet to provide a plan for excluding readmissions unrelated to the initial reason for admission.
The AHA also believes that the readmissions penalty formula imposes penalties disproportionate to the costs of excess readmissions. The formula is driven by statute and is quite complex. However, a June 2012 MedPAC analysis demonstrates that, in general, the payment penalty is the product of two elements:

- The “excess cost” of readmissions, which is the DRG payment rate for the condition in the HRRP times an adjusted number of “excess readmissions” for that condition; and

- A “penalty multiplier,” which is equal to 1 divided by the national readmission rate for the condition.\(^2\)

Using the same simplified example as the MedPAC report, assume that the national readmissions rate for a given DRG is 20 percent. If a hospital has 100 admissions in that DRG, then the expected number of readmissions is 20. If a hospital had 22 actual readmissions, then the number of excess readmissions would be 2. If the base DRG payment was $10,000, and the costs of the readmission were the same as the initial admission, then the cost of excess readmissions would be $10,000 x 2 = $20,000. However, since there is a penalty multiplier of 1/the national readmission rate, the penalty is actually five times greater \((1/0.2 = 5)\) than the cost of the excess readmissions in a given DRG, or $100,000 in this example.

The penalty’s inverse relationship between the national readmission rate and the magnitude of penalty also may punish hospitals for making progress in reducing readmissions. Indeed, if the national readmission rate in the example above dropped from 20 percent to 10 percent, the penalty multiplier actually grows from 5 to 10. In the long run, the formula as currently constructed is unfair and counterproductive. This directly contradicts the goal of the program. In the coming year, the AHA will work with CMS and others to improve the measures used and to ensure the payment penalty is fair.

Hospital-acquired Condition (HAC) Payment Reduction Program. In the coming year, the AHA will work with CMS and others to improve the measures used, and to ensure the payment penalty is fair. The DRA requires CMS to identify HACs that are high cost or high volume or both; result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence based guidelines. Since FY 2009, inpatient hospital discharges are not assigned to a higher paying DRG if a selected HAC is not coded as present on admission (POA). HAC measures are derived from Medicare claims, and

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currently include foreign objects retained after surgery, air embolisms, blood incompatibility, pressure ulcers, vascular catheter-associated infections, catheter-associated urinary tract infections, falls and trauma, and glycemic control.

The ACA’s HAC payment reduction program goes one step further, applying a financial penalty to hospitals with high risk-adjusted rates of HACs in the DRA HAC policy, or any other quality measures selected by the Health & Human Services Secretary. Beginning in FY 2015, hospitals in the top quartile of national HAC rates will receive a 1 percent reduction to Medicare payments for all discharges. We expect to learn more about the program’s implementation in the coming year, including what specific quality measures may be used to determine payment penalties.

The AHA has concerns about the selection of quality measures in the ACA-mandated HAC payment reduction program, as well as the fairness of the payment penalty. As mandated by the ACA, the Measure Applications Partnership recently completed its yearly review of measures being considered for several federal quality reporting and payment programs. This process provides a preview of the measures that will be included in formal rules. Many of the same measures were proposed for both HAC and VBP. Using the same measures in more than one pay-for-performance program may subject hospitals to unfair double payment penalties. Moreover, the different constructs of the programs and the disparate ways in which good versus bad performance is identified could send potentially conflicting signals to patients and hospitals. Indeed, a hospital’s performance in one program could appear acceptable or even good, but in the other program may appear unacceptable or deserving of a payment penalty. To avoid such conflicting signals, it may be appropriate to consider giving heavier weight to a measure in one program, and removing it from the other.

The AHA also will discourage CMS from using the claims-based HAC measures currently in the DRA-mandated HAC program. These measures were considered for the VBP program and demonstrated poor reliability in a CMS-commissioned analysis. Moreover, many of the HACs, particularly retained foreign objects and air embolisms, occur very rarely. Hospitals may score in the top quartile, and be subjected to a payment penalty, if they have even one or two such events in a given year.