American Hospital Association®

Quality Reporting and Pay-for-Performance

Background

Quality measurement is at the center of a wide range of efforts to improve hospital performance, and to transform the payment system from a volume-based methodology to one that rewards value-that is, better quality at the same or lower cost. More than 10 years ago, hospitals initiated efforts to publicly report quality data in order to share important and reliable information with the communities they serve, identify opportunities to improve care and be able to track their improvements. Subsequently, this public reporting of quality measures was linked to Medicare hospital reimbursement through the Hospital Inpatient Quality Reporting Program. 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 full annual payment updates.

The Affordable Care Act (ACA) expanded quality measurement efforts by introducing new pay-for-reporting programs for inpatient psychiatric facilities, prospective payment system-exempt cancer hospitals, long-term acute care hospitals and inpatient rehabilitation facilities. The ACA also established "pay-for-performance" programs that reduce Medicare reimbursement to hospitals and physicians who score below national performance benchmarks on selected quality measures. For hospitals, some of the areas measured include readmissions, hospital-acquired conditions, mortality, patient experience of care, and clinical process measures of heart attack, heart failure and pneumonia.

AHA View

The AHA believes that well-conceived public quality reporting and pay-for-performance programs can align the health care delivery system toward continuous quality improvement. To date, however, federal quality reporting and payment programs have proliferated without strong alignment to specific, measurable national improvement objectives and goals for quality improvement. As a result, the sheer volume of measures and disparate ranking and rating efforts have become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance coordination across the care continuum. Moreover, the AHA is concerned that certain quality measures in federal programs do not lead to better outcomes for patients or do not produce accurate performance results. Lastly, we believe the manner in which some of the payment penalties are calculated lacks fairness and equity.

To ensure federal pay-for-performance programs promote better health, better care, lower cost and greater engagement of patients in their own health care, the AHA's efforts are focused on both strategic and program-specific issues, which are outlined in detail below.

Enhancing Alignment of Quality Measurement. At a time when health care resources are under intense scrutiny, an aligned, focused and rigorous approach to quality measurement and pay-for-performance programs can ensure that such

programs are targeted at areas that will truly drive the most meaningful improvements across the health care delivery system. Broadly defined, alignment means that measurement priority areas are the same across payment programs, and that the decision to use particular measures in a particular program is driven by a consistent set of principles. For example, a well-crafted measure of pressure ulcers may be suitable for every setting where patients are at risk. However, alignment also may mean using measures that assess different providers' responsibilities in achieving an overall desired goal. For example, if the goal is to reduce early mortality from heart disease, the Centers for Medicare & Medicaid Services (CMS) could use a series of aligned measures in which primary care clinicians are assessed on their ability to manage blood pressure and diabetes in their patient population, hospitals are assessed on their proficiency in re-profusing the heart muscle quickly (e.g., door-to-balloon time), and cardiac rehab facilities are assessed on their ability to improve patients' ability to return to activities of normal living.

CMS should select the most accurate and reliable measures for programs so that consumers have dependable information to inform their decisions, and so providers can appropriately benchmark performance. Specifically, CMS should begin this work in collaboration with the National Priority Partnership – a body that was originally envisioned as a multi-stakeholder group that could provide important input on a small number of specific national priority areas.

The AHA has repeatedly urged CMS to use a consistent process to add measures to its quality reporting and pay-for-performance programs. Adherence to the steps outlined below would encourage the selection of the best available measures to both accurately reflect provider performance and address issues of high priority:

- Measures implemented in federal programs should be reviewed and endorsed by the National Quality Forum (NQF) prior to inclusion in a federal program to ensure that each measure is important, scientifically sound, useable and feasible to collect.
- Federal programs should require that measures being considered for inclusion be reviewed by the Measure Applications Partnership (MAP) before they are formally proposed in rulemaking.
- Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year so appropriate adjustments and potential unintended consequences can be identified and addressed.
- When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs to create room for new measures.

Inpatient Quality Reporting (IQR) Program. The IQR program requires that hospitals submit data on quality measures designated by CMS. In turn, those measures are publicly reported on the Hospital Compare website. Hospitals that fail to meet IQR reporting requirements are subject to a 2 percent reduction in their annual payment update. As part of the IQR, CMS can choose to use claims data to calculate and publicly report hospital performance, as it has for readmission and mortality measures. Currently, hospitals report 57 measures under the IQR.

Stroke is a common reason for hospital admission, and it is appropriate for CMS to want to measure and improve the quality of stroke care. Unfortunately, the two measures chosen – stroke mortality and readmission within 30 days of hospital discharge – fail to accurately reflect hospital performance. The AHA continues to urge CMS not to use these measures in any federal programs until adequate adjustments for stroke severity can be made.

Value-based Purchasing (VBP). Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures. The VBP program is budget-neutral. That is, it is funded by reducing all inpatient prospective payment system (PPS) Medicare-severity diagnosis related group (MS-DRG) payments by a certain percentage, and all the funds withheld must be paid out to hospitals. The reduction is applied to the operating base MS-DRG and does not affect indirect medical education (IME), disproportionate share hospital (DSH) or outlier payments. The payment reduction is 1.25 percent in FY 2014, and will continue to rise by 0.25 percent each year, topping out at 2 percent in FY 2017 and beyond. For FY 2014, CMS estimates that approximately $1.1 billion will be available to redistribute to hospitals as VBP payments.

VBP measures are selected from among those used in the Medicare IQR program and must be reported in the IQR for at least one year before they are used in VBP. For FY 2014, CMS finalized 17 measures for the VBP program. This will increase to 19 measures in FY 2015. To calculate VBP payments, CMS establishes “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.

In general, the AHA favors pay-for-performance programs, such as VBP, that assess multiple aspects of care and that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance. We

believe this incentive structure can provide greater inducement for providers to improve performance. **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:**

- O*utcome Measure Reliability:* 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. Beginning in FY 2014, CMS will use three 30-day mortality measures. 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.
- *HCAHPS Measures:* We believe CMS should assign a lesser weight to scores from the Hospital Consumer Assessment of Health Providers and Systems (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.

Hospital Readmission Reduction Program (HRRP). The HRRP imposes financial penalties on hospitals for "excess" readmissions when compared to "expected" levels of readmissions. The potential penalty increased to 2 percent of base payments in FY 2014 and will increase to 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 IQR. Beginning in FY 2015, CMS will add measures for chronic obstructive pulmonary disease and patients undergoing total hip or knee replacement.

America's hospitals are committed to reducing unnecessary readmissions. However, early experience with the HRRP shows that hospitals caring for the poorest patients are disproportionately more likely to incur penalties under the program. Hospitals treating a higher proportion of poor patients fare worse in the HRRP because the current HRRP fails to recognize that community factors outside the control of the hospital – such as primary care, mental health services, physical therapy, easy access to medications and food that meets the patient's prescribed diet, and other rehabilitative services – play a significant role in determining how likely it is that a patient's health will continue to improve 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 the proportion of patients dually eligible for Medicare and Medicaid, and this data could be used to adjust penalties. The AHA strongly

urges CMS, Congress and others to incorporate into the HRRP an appropriate adjustment for socioeconomic factors so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized under the HRRP.

In addition to adjusting for socioeconomic factors, the AHA continues to urge CMS to exclude readmissions unrelated to the initial reason for hospitalization, as required by the ACA. The AHA successfully advocated for a provision in the ACA 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.

Hospital-acquired Condition (HAC) Reduction Program. In August 2013, CMS released its inpatient PPS final rule implementing the HAC program's eligibility requirements, specific measures and scoring methodology. In general, HACs are adverse, potentially preventable safety events, such as central-line associated bloodstream infections, pressure ulcers and falls with serious injury. By statute, the HAC program must impose a 1 percent reduction to total inpatient MS-DRG payments (including IME, DSH and outliers) for hospitals in the top 25 percent of risk-adjusted national HAC rates beginning in FY 2015. Thus, even if an individual hospital significantly improves its performance from one year to the next, it may still be subject to a penalty. Similarly, even if the hospital field as a whole achieves strong performance, one quarter of all hospitals will still be unfairly subject to payment reductions.

The AHA has a number of concerns with the HAC program. First, the HAC measures are unnecessarily duplicative with those in the VBP program. This has the potential not only to create excessive double payment penalties, but also to lead to 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 HAC program, but not both programs. Second, data show that hospitals treating complex patients will be disproportionally penalized under the HAC program. We continue to urge CMS to identify additional NQF-endorsed measures that address safety issues affecting as broad a range of hospitals as possible. Finally, the HAC program would use PSIs based on claims data to identify patients that have potentially experienced a safety event. We are concerned that the rates derived from the PSI measures are inexact and simply not rigorous enough for public reporting or payment penalty application as they fail to accurately and meaningfully reflect hospital performance.

America's hospitals are deeply committed to reducing preventable patient harm. However, as currently designed, the HAC Reduction Program 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 make improvements to the existing policy, as well as promote alternatives to the HAC program that more effectively promote patient safety.

Electronic Clinical Quality Measures (eCQMs). The movement toward adoption of electronic health records (EHRs) should facilitate the greater ease in calculation and reporting of clinical quality measures for hospitals. Hospitals are eager for real-time access to information from their EHRs to support quality improvements. With the intention of accelerating the adoption of EHR-enabled quality measurement, CMS and the Office of the National Coordinator for Health IT (ONC) require hospitals to report data on more than a dozen eCQMs as part of the Medicare EHR Incentive Program. These eCQMs assess areas such as stroke care, the prevention of venous thromboembolism and the frequency of early elective deliveries. CMS has expressed strong interest in aligning the reporting of quality data in the Medicare EHR Incentive Program with the IQR program. To that end, CMS adopted a policy in the FY 2014 inpatient PPS final rule that allows hospitals to voluntarily report one quarter of data for 16 IQR program quality measures using EHRs certified in the Medicare EHR Incentive Program, thereby receiving credit in both programs.

To date, however, CMS and ONC's efforts have not enabled EHRs to generate feasible, reliable and valid quality data for reporting purposes. Due to insufficient testing of measure specifications and data abstraction methods, the eCQMs do not provide accurate representations of hospital performance. Efforts to simply display data reported from EHRs undermines the intent of the federal public quality reporting efforts – that is, to provide consumers with reliable data on quality of care, and to enable providers to benchmark and improve their performance. In addition, a recent study commissioned by the AHA shows that efforts to capture eCQM measure data significantly adds to clinicians' workload without perceived benefit to patient care.[1]

For these reasons, the AHA continues to urge CMS and ONC to slow the pace of the transition to electronic quality reporting to allow for policy and technology challenges to be addressed. Technology testing also needs to occur in order to assess the readiness of EHRs to support a safe and credible transition from chart-abstracted measures to eCQM reporting. (Refer to the AHA issue paper, "Health Information Technology," for more information.)

Physician Quality Reporting and Pay-for-Performance. Physicians and other eligible professionals (EPs) participate in CMS quality reporting and pay-for-performance programs that operate independently of hospital programs. Under the physician quality reporting system (PQRS), individual physicians and physician

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[1] A summary, along with the full study, are available at *http://www.aha.org/research/policy/ecqm.shtml*

groups are required to report quality measures to earn an incentive payment or, beginning in 2015, avoid a payment penalty. The physician value-based payment modifier (VBM) ties payment to performance on PQRS measures, with physicians eligible for an upward or downward payment adjustment of 1 percent in 2015, and 2 percent in 2016. To date, the reporting requirements, measures and scoring methodology for PQRS and VBM have been completely different than those used in analogous programs for hospitals.

However, hospitals have become increasingly focused on physician quality reporting and pay-for-performance programs as physician integration efforts become more prevalent. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. In addition to direct employment, hospitals contract with physicians on a group or individual basis, such as emergency physicians or hospitalists. Hospitals and physicians are eager to capitalize on integration efforts to better align quality improvement goals and strategies, thereby improving care across the continuum.

To further encourage this alignment, the AHA urges CMS to allow hospital-based physicians to use their hospitals' inpatient and outpatient quality reporting measures and data to meet PQRS and VBM requirements. Using hospital-based measures would allow hospitals and affiliated physicians to be held accountable for performance on the same issues, thereby enhancing coordination and leading to improved quality and efficiency for patients.

Post-acute Care Quality Measurement. Quality reporting efforts for post-acute providers have greatly expanded in recent years. In addition to the previously existing quality reporting programs for nursing homes and home health providers, the ACA mandated quality reporting for long-term acute care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs) beginning in October 2012. In general, the AHA believes that rigorous, transparent measure reporting efforts are critically important to improving the quality, safety and value of post-acute care.

To ensure the long-term credibility of such efforts, the AHA urges CMS to select for its post-acute quality reporting programs only those measures that are specified, tested and NQF-endorsed for the care setting (e.g., LTCHs, IRFs) in which they will be used. For instance, CMS finalized a measure assessing the proportion of patients experiencing one or more major falls with injury for the long-term care hospital quality reporting (LTCHQR) program. Reducing patient falls is a critically important goal; however, the measure in the LTCHQR is specified, tested and NQF-endorsed for use in nursing homes, not LTCHs. The practice of using measures for one care setting and applying them to another without adequate specification and testing may result in measure results that do not accurately reflect provider performance.

Similarly, the AHA is concerned that the readmission measures finalized for CMS's post-acute reporting programs have not yet been NQF endorsed, and as a result, the field has limited information about their validity, reliability and usefulness in reducing readmissions. We agree that post-acute providers are critically important to reducing hospital readmissions. However, measurement efforts must be carefully structured to help, and not hinder, collaboration across the entire care continuum. Moreover, measures must be carefully risk adjusted to ensure that providers do not score poorly because of factors beyond their control, such as severity of illness, or community factors that compromise access to needed support resources. As the AHA has urged, CMS submitted the readmission measures as part of an NQF endorsement review committee on readmission measures. The AHA will carefully monitor this project and advocate that CMS use only those readmission measures that successfully attain NQF endorsement.