Healthcare Quality program Renovation

Where are we and where do we go…

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Social & Scientific Systems

How are we measuring and paying for quality for hospitals in Medicare?

- Hospital inpatient quality reporting program
  - Pay for reporting program (0.8 percent adjustment in 2020 for not reporting)
  - Data from program available on hospital compare
- Hospital outpatient quality reporting program
  - Pay for reporting program
  - Includes 21 measures
  - Data available on Hospital Compare

Hospital readmission reduction program

- Targeted to six conditions (AMI, heart failure, pneumonia, COPD, hip and knee replacement, CABG surgery)
- Penalties for hospitals' with above average readmission rates for a condition
- Benchmark readmission rates set by hospital peer groups based on share of dual eligible beneficiaries (Started in FY 2019)
- Overall more than 80 percent of hospitals receive a penalty –total penalties in FY 2019 estimated to be $566 million

Hospital value based purchasing program

- Clinical outcome domain
  - 30 day mortality (AMI, heart failure, and pneumonia)
  - Complication rate for hip and knee replacement surgery
- Patient and care giver centered experience of care domain
  - HCAHPS survey
- Safety domain
  - Six patient safety measures: CAUTI, CLABSI, CDI, MRSA, SSI (colon surgery and abdominal hysterectomy), Elective delivery < 39 weeks
- Efficiency and cost of care domain
  - Medicare Spending per Beneficiary
- Each domain given a 25 percent weight
- 2 percent of Medicare payments put at risk
- Complicated scoring algorithm allows for winners and losers

Hospital-Acquired Condition Reduction Program

- Hospital performance measured on multiple hospital acquired conditions:
  - PSI90 (includes 10 patient safety indicators)
  - CAUTI *
  - CLABSI *
  - CDI *
  - MRSA bacteremia *
  - SSI *
- Equal weighting across all measures that have sufficient cases
- Use Winsorized Z-score methodology s
- Worst performing quartile of hospital recieve a 1 percent penalty

Do we need to revise Medicare's hospital quality incentive programs?

- Are we measuring what matters?
- Are current measures clinically credible?
- Are they actionable; Can we induce change that improves quality of care?
- Do performance targets reflect best practices?
- Are the financial incentive appropriate; Are they strong enough to induce quality improvement?
- How can we improve what Medicare does?

Issues with current hospital quality payment programs

- Inconsistent with the Commission's quality measurement principles
- Contain too many, overlapping programs
- Rely on condition-specific readmission and mortality measures as opposed to all-condition measures which are more stable
- Include process measures that are not tied to outcomes, and provider-reported measures that may be inconsistently reported
- Score hospitals using "tournament models" (hospitals are scored relative to one another) and not clear, absolute, and prospectively set performance targets

MedPAC's HVIP design

Merge programs:

Hospital Readmissions Reduction Program (HRRP)

Hospital Value-based Purchasing (VBP) Program

Hospital-Acquired Condition Reduction Program (HACRP)

Eliminate program:

Inpatient Quality Reporting Program (IQRP)

Hospital Value Incentive Program (HVIP)

- Include five outcome, patient experience and cost measure domains
  - Readmissions
  - Mortality
  - Spending (MSPB)
  - Patient experience
  - Hospital-acquired conditions
- Set clear, absolute and prospective performance targets
- Account for social risk factors by directly adjusting payment in "peer groups"
- Distribute a pool of dollars to hospitals based on their performance

What about Rich's proposal

- Includes both inpatient and outpatient measures—Medicare quality financial incentives currently only on inpatient payments
- Limited number of measures which helps to simplify the program
- Claim-based focus—Don't we also need to be concerned about patient experience?
- Movement to targets based on best practices better than focusing on average—need to avoid the moving targets that are part of the current Medicare program
- But how will best practices be identified and disseminated?
- Not clear how proposal address socio economic/demographic issues that may lead to disparities in performance and financial hardship for some providers

Questions?

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