Evolution of Hospital Pay for Reporting and Pay for Performance Programs

- Inpatient Quality Reporting Program (Supported by QIO)
- Value-based Purchasing (Supported by QIN-QIO)
- Readmission Reduction Program (Supported by RARE)
- Hospital Acquired Condition Program (Supported by CHAIN)
- Meaningful use (Supported by REACH)
- eRX Incentive Program (Supported by QIN-QIO)
- Physician Quality Reporting System (Supported by QIN-QIO)
- Meaningful Use (Supported by REACH)
- Physician Value-Modifier (Supported by QIN-QIO)
- Quality Payment Program
  - Merit-based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (Supported by QIN-QIO)

- Accountable Care Organizations (ACO)
- Practice Transformation Networks (PTN)
- Quality Practice Improvement Activities (QPIA)

This material was prepared by Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy.
Overview of Federal Programs

Value-Based Purchasing (VBP) Program
CMS Incentive Program for PPS Hospitals
The purpose of the Hospital VBP program is to achieve value by tying payment to quality of care. Measure scores are either determined by improvement as compared to an individual hospital’s baseline performance or achievement as compared to the baseline threshold and benchmark performance of all hospitals; whichever is greater. These are rolled up into domain scores, which are weighted to determine the total performance. Domain weightings in FY2018 are as follows:

- 25% - Clinical Care
- 25% - Patient Experience of Care
- 25% - Safety
- 25% - Efficiency

Each domain score is multiplied by its weight. The sum of those determines the Total Performance Score (TPS) for each hospital.

For more information, including allowable exclusions and a list of the measures that make up the domains in FY2018, see the Understanding Value-Based Purchasing Fact Sheet.

Healthcare Acquired Conditions (HAC) Program
CMS Incentive Program for PPS Hospitals
The purpose of the HAC program is to reduce harm and increase patient safety by tying payment to performance related to conditions patients acquire while receiving care in an acute care setting for something else. Measure scores are determined by a Z-score, which represents a hospital’s distance from the national mean for a measure in units of standard deviation. For domain 1, there is only one measure, so the domain score is the same as the measure score. An average of the measure scores is used to determine the score for domain 2. Domain weightings FY2018 are as follows:

- 85% - Domain 1: Patient Safety Indicators
- 15% - Domain 2: National Healthcare Safety Network Measures

Each domain score is multiplied by its weight. The sum of those determines the Total HAC Reduction Score for each hospital.

For more information, including allowable exclusions and a list of measures that make up the domains in FY2018, see the Understanding the Hospital-Acquired Conditions Reduction Program Fact Sheet.

Readmission Reduction Program (RRP)
CMS Incentive Program for PPS Hospitals
The purpose of the RRP is to reduce unplanned re-hospitalizations and cost by tying payment to excess readmissions. Excess readmissions are calculated as the ratio of predicted readmissions to expected readmissions. CMS does not calculate a composite score for the RRP; however, public results from the CMS Readmission Reduction Program are used to calculate a composite measure for Minnesota hospitals.

For more information, including allowable exclusions and a list of the measures for FY2018, see the Understanding the Hospital Readmissions Reduction Program Fact Sheet.
Medicare Beneficiary Quality Improvement Project (MBQIP)
Federal Office of Rural Health Policy (FORHP) Initiative

MBQIP is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program aimed at improving the quality of care provided in Critical Access Hospitals (CAHs), by increasing quality data reporting and driving quality improvement based on the data. Measures are selected based on rural relevancy in an attempt to ensure hospitals are tracking on process and outcomes that can provide meaningful data and the greatest impact to their patient population.

The majority of MBQIP measures are stand-alone measures, meaning they do not result in a composite score. Current exceptions to this include the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the Emergency Department Transfer Communications (EDTC), both of which result in composite scores.

MBQIP measures are divided into two categories of Core Improvement Activities and Additional Improvement Initiatives, as well as being divided among four domains:

- Patient Safety
- Patient Engagement
- Care Transitions
- Outpatient

There are no payment implications related to MBQIP at a federal level, however participation at varying levels is required in order to participate in some FORHP funded programming.

For a list of the measures currently included in MBQIP, see the MBQIP Measures reference sheet.
SQRMS-Specific Hospital Measures

While a vast majority of SQRMS hospital measures align directly with established federal programs, there are a few that are required only as a part of the Minnesota SQRMS program.

**Minnesota Stroke Registry**
Requires hospitals to submit data to the Minnesota Department of Health regarding patients treated for stroke in the emergency department.
- Door-to-Imaging Initiated Time
- Time to Intravenous Thrombolytic Therapy

**Surveys**
Minnesota-specific questions are added to the American Hospital Association annual survey, as determined by the Minnesota Department of Health and collected by the Minnesota Hospital Association.
- Health Information Technology (HIT) Survey

**Agency for Healthcare Research and Quality (AHRQ) Measures**
All AHRQ measures required by SQRMS are claims-based, and therefore do not result in an additional reporting burden to hospitals. Two of the AHRQ measures required by SQRMS are calculated for PPS hospitals under other programs; all of the AHRQ measures are uniquely required by SQRMS for CAHs.
- PSI-04: Death Rate Among Surgical Patients with Serious Treatable Complications
  - PPS hospitals – required for Inpatient Quality Reporting Program
  - CAHs – required as part of SQRMS
- PSI-90: Patient Safety and Adverse Events Composite
  - PPS hospitals – required for VBP and HAC
  - CAHs – required as part of SQRMS
- IQI-91: Mortality for Selected Measure Composite (claims-based)
  - PPS hospitals – required as part of SQRMS
  - CAHs – required as part of SQRMS
Updates to Federal Programs

CMS Incentive Programs for PPS Hospitals
The following are updates made to CMS Incentive Programs for PPS Hospitals affecting FY2018 program scores.

Value-Based Purchasing (VBP) Program
- Clinical Care – Process Domain Changes
  This domain was removed entirely. Measures previously included:
    - AMI-7: Fibrinolytic Agent Received Within 30 Minutes of Hospital Arrival
    - IMM-2: Influenza Immunization
    - PC-01: Elective Delivery (note: moved to Safety domain)
- Patient Experience of Care Domain Changes
  - Removed Pain Management as an HCAHPS Survey Dimension
  - Added Care Transitions as an HCAHPS Survey Dimension
- Safety Domain Changes
  - Added PC-01: Elective Delivery (note: moved from Clinical Care – Process domain)

Healthcare Acquired Conditions (HAC) Program
CMS Incentive Program for PPS Hospitals
- Scoring for HAC measures changed from being a score of 1-10 based on a hospital’s national percentile ranking, to being determined through a Winsorized z-score, which represents a hospital’s distance from the national mean for a measure in units of standard deviation.
- Modified PSI-90 Measure (Domain 1) Changes:
  - Removed PSI-07: Central venous catheter related blood stream infection rate
  - Added PSI-09: Perioperative hemorrhage or hematoma rate
  - Added PSI-10: Postoperative acute kidney injury requiring dialysis rate
  - Added PSI-11: Postoperative respiratory failure rate
  - Re-specified PSI-12: Perioperative pulmonary embolism or deep vein thrombosis rate
  - Re-specified PSI-15: Unrecognized abdominopelvic accidental puncture/laceration rate

Readmission Reduction Program (RRP)
CMS Incentive Program for PPS Hospitals
No changes expected.
CMS Pay for Reporting Programs for PPS Hospitals
The following are updates made to CMS Pay for Reporting Programs for PPS Hospitals affecting data submission in calendar year 2018.

Inpatient Quality Reporting (IQR) Program
CMS Pay for Reporting Program for PPS Hospitals
No changes known at this time. Next proposed rule anticipated in April 2017; final rule anticipated in August 2017.

Outpatient Quality Reporting (OQR) Program
CMS Pay for Reporting Program for PPS Hospitals
- Added OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
- Added OP-36: Hospital Visits after Hospital Outpatient Surgery
- Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)
  - Added OP-37a: OAS CAHPS – About Facilities and Staff
  - Added OP-37b: OAS CAHPS – Communication About Procedure
  - Added OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
  - Added OP-37d: OAS CAHPS – Overall Rating of Facility
  - Added OP-37e: OAS CAHPS – Recommendation of Facility

Medicare Beneficiary Quality Improvement Project (MBQIP)
The following measures are under consideration for being moved from the category of Additional Improvement Initiatives to Core Improvement Activities under the domain of Patient Safety:
- Catheter Associated Urinary Tract Infections (CAUTI) – note: currently required by SQRMS
- *Clostridium difficile* Infection (CDI)
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia
For several years, the Hospital Quality Reporting Steering Committee has noted that there are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system. Of note, there is a growing body of research related to organizational properties and systems which are essential to safety. In addition, the current measures are not easily understood or meaningful to consumers. In order to try to make patient safety hospital measurement more meaningful and comprehensive, the Committee recommended in 2016 building upon the current individual measures and moving to a multi-faceted patient safety index or composite measure that would represent essential components of safer care. The recommendation to explore the creation of a patient safety composite was supported by the Minnesota Department of Health. As a result, the Patient Safety Workgroup, a subset of the broader Hospital Quality Reporting Steering Committee, was chartered in 2016 to explore a patient safety composite measure for SQRMS in Minnesota.

In June 2016, the workgroup started by first seeking to clarify criteria and the process that would be used to adopt or adapt a composite measure. The group worked to understand whether the primary purpose of a safety composite measure is to be meaningful to consumers or health care providers, or to both. The needs of the consumer were felt to be the priority, which led initially to looking at clinical care and patient harm (and not the organizational/system domain) as part of the composite measure. However, the group evolved in its thinking, and determined that the organizational and system characteristics are equally important to drive improvement in patient safety, and as such, should be included as part of a composite measure. The group then pursued assessed whether there was an existing composite measure which would meet our needs, given how rapidly the measurement environment was and is changing.

Leapfrog was identified as a possible match. As a national nonprofit organization that collects and transparently reports hospital performance through its longstanding hospital survey processes, Leapfrog makes available the methods for how measures are developed, collected and calculated so that a hospital can see how every score is derived.

**Leapfrog (LF) Overview**

The overall Leapfrog program consists of an annual survey (which has been available since 2001) and two composite scores:

- A publicly reported Hospital Safety Grade, comprised of approximately half CMS measures and half survey-derived measures
- A Value-Based Purchasing Platform, a composite measure derived from survey responses, and not publicly reported
The Patient Safety Workgroup focused its attention on the Value-Based Purchasing Platform to try to determine if the platform could serve as a means to provide a comprehensive safety composite measure that was inclusive of clinical care and harm measures, as well as organizational and system characteristics for Minnesota SQRMS.

The Value-Based Purchasing Platform is a composite of measures from the Leapfrog Hospital Survey. Therefore, any hospital that submits an annual survey is eligible to participate as part of the composite. The VBP Platform score includes clinical process measures and outcome measures, as well as organizational and system measures. Through conversation with LF to date, the workgroup learned that other states have prioritized certain aspects of safety, and have then selected to use a subset of measures from the survey in line with their state’s priorities. If Minnesota opted to use only certain sections of the LF survey for SQRMS purposes, all hospitals would be compared on those same sections to create the Minnesota “report.” While there is more to be understood about the LF VBP Platform before it could be determined if the platform would meet the interests and needs for a SQRMS Patient Safety composite measure, LF has indicated it would be willing to work with MN to understand the specific measures of interest and the weighting of those measures.

With the Value-Based Purchasing (VBP) Platform a numeric score is assigned 1-100 (with 100 being the best), based on 24 measures in five domains. The domains are:
- Medication Safety (15%)
- Inpatient Care Management (20%)
- High-Risk Surgeries (15%)
- Maternity Care (15%)
- Infections & Injuries (35%)

The Platform then calculates an overall composite score, the Value Score. If a hospital does not perform a certain service (e.g., surgery, maternity care), the measure is “unable to calculate” and a hospital is not penalized in the composite scoring. The Value-Based Purchasing Platform has been used in other states with low volume and critical access hospitals.

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Funding provided by the Minnesota Department of Health through a contract with Minnesota Community Measurement.
HQRSC
Patient Safety Workgroup
Safety Composite Measure Recommendation to Hospital Quality Reporting Steering Committee
March 2017

The Hospital Quality Reporting Steering Committee chartered a patient safety workgroup in March 2016, which carried out its work June 2016 through February 2017. Based on deliberations, discussions, and preferences expressed by Workgroup members, two options have been eliminated, leaving two options for consideration.

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<th>Option 1</th>
<th>Option 1.5</th>
<th>Option 2</th>
<th>Option 3</th>
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<td>Develop or adapt, and publicly report, a comprehensive safety composite measure inclusive of clinical care and harm measures, as well as organizational and system characteristics</td>
<td>Develop or adapt, and publicly report, a patient safety composite measure focused on clinical care and harm (which is Option 2), RLUS, require hospitals to report to the state their domain-level patient safety culture survey result (which is part of Option 1). The safety culture domain results would not be publicly reported at an individual hospital level, but in the aggregate.</td>
<td>Develop or adapt, and publicly report, a patient safety composite measure focused on clinical care and harm</td>
<td>Do not develop or adapt, and publicly report, anything new at this time, recognizing that there are already a number of safety measures and composites. (While no action would be recommended now, monitoring the changing safety measurement environment would continue to be a HQRSC role.)</td>
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Option 1: The recommendation to the Hospital Quality Reporting Steering Committee: “Pursue the use of Leapfrog Value-Based Purchasing Platform as a patient safety composite measure for Minnesota hospitals, to be reported as part of SQRMS.”

Considerations:
- If the workgroup recommends pursuit of Leapfrog as a patient safety composite measure for SQRMS, the details of the program (i.e., program design, measure prioritization, appropriate CAH data display, etc.) would need time and attention to be worked out. This would likely be a subgroup, inclusive of MDH and MNCM, starting in the latter half of 2017 to prepare for a 2018 detailed
recommendation, pending contract renewal by MDH. A publicly reported safety composite measure would be in place in 2019 at the earliest.

- If the details cannot be worked out in such a way that the subgroup sees aligning with SQRMS goals and Minnesota needs, the recommendation to the Hospital Quality Reporting Steering Committee in 2018 may be to discontinue pursuit of a patient safety composite measure.

**Option 3:** The recommendation to the Hospital Quality Reporting Steering Committee: “No patient safety composite measure recommended at this time.”

Considerations (potential Hospital Quality Reporting Steering Committee action):
- Re-visit at a future date (potentially 2019).
- Monitor the new CMS required measure for PPS hospitals -- Hospital Survey on Patient Safety Culture -- to see what is learned and whether there is an opportunity to build on it for a MN/SQRMS-specific measure.

Of note, potential actions which fall outside of the scope of the Hospital Quality Reporting Steering Committee have been mentioned at previous workgroup meetings:
- Take an advocacy role regarding measure burden at the national level.
- Focus in improvement, not public reporting (e.g., develop and implement a safety improvement campaign or initiative in Minnesota, led collaboratively by organizations already doing safety improvement work).

**Patient Safety Workgroup Voting**
Five of the six workgroup members were present at the workgroup’s meeting on February 27, 2017, and voted as follows:

Two votes which could support either option, but both leaning toward #3:
- In one case, because the value to critical access hospitals isn’t clear in option #1.
- In one case, because the feasibility of Leapfrog isn’t clear.

One vote for #3.
- But noting that the workgroup member would participate in the process if option #1 is selected.

Two votes for #1.
- In one case, because #1 seems low risk, and discomfort with option #3.
- In one case, status quo of #3 is not acceptable; however, the feasibility of #1 is unclear.