Issue Brief

Health Economics and Market Access
Office of Medical Affairs

Pay-for-Performance

2019

Medicare Pay-for-Performance Programs

Medicare's efforts to increase value in health delivery are reflected in the pay-for-performance (P4P) incentives it has added to the inpatient hospital prospective payment system. All of these provisions reward or penalize hospitals financially based how well the hospital performs on specific outcomes, cost, or quality standards.

Hospital-Acquired Conditions	Penalty for cases in which the patient acquired a new illness/condition during a hospital stay
Preventable Readmissions	Penalty for excessive rate of readmissions that could have been managed/prevented
Value-Based Purchasing	Reward for meeting quality and value standards on a range of conditions

Hospital-Acquired Conditions

Medicare reduces inpatient payments for conditions or injuries the patient acquires during a hospital stay. It does so in two ways:

- *Medicare no longer pays hospitals for the additional costs of treating 14 conditions/injuries patients acquire once they have been admitted.*

  - ✓ Includes falls and trauma, surgical site infections, blood incompatibility, and advanced pressure ulcers, among others.
  - ✓ To determine whether conditions are acquired in the hospital, Medicare examines hospital claims, discharge, and admissions data. If the conditions are not noted when the patient is admitted, Medicare will not pay.

For example, if a patient is admitted with a primary diagnosis of a stroke but also fell at home and fractured a hip, Medicare will pay for treating the hip fracture (known as a complicating condition) in addition to treating the stroke. If the patient is admitted with a stroke diagnosis and falls while in the hospital, Medicare will not pay additionally for that "complicating condition."

- *In addition, Medicare cuts payments by 1% if hospitals are among the 25% worst-performing hospitals nationwide in reducing hospital-acquired conditions.*

  - ✓ To determine hospital performance, Medicare gives each hospital a score based on how well it performs in 15 individual measures, including such conditions as hip fractures, surgical infections, and pressure ulcers.

The measures are grouped into two domains—one for patient safety, one for infections. Then, each domain is weighted and used to calculate an overall performance score.

Although Medicare pays providers on a fee-for-service basis up front, it makes these calculations and adjustments two years after the care has been delivered. Thus, data from 2014 – 2016 were used in assessing penalties in FY 2018.

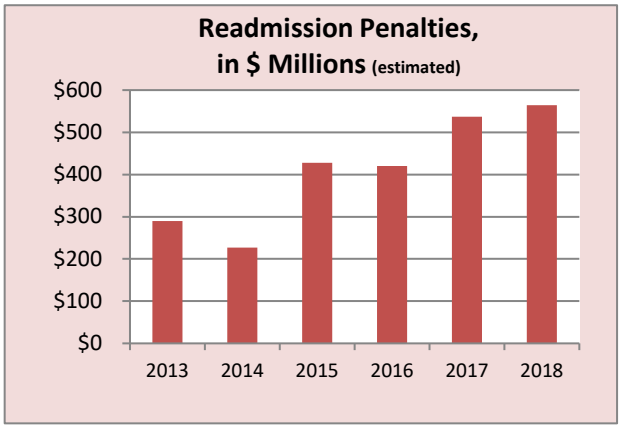
Preventable Readmissions

Medicare reduces payment for hospitals that have high rates of preventable readmissions.

- "Preventable Readmissions" are those in which patients are readmitted to a hospital within 30 days after having been hospitalized for these conditions:

  - ✓ Heart failure
  - ✓ Pneumonia
  - ✓ Heart attack
  - ✓ Chronic obstructive pulmonary disease
  - ✓ Elective hip or knee replacement
  - ✓ Coronary artery bypass graft

- The maximum penalty = 3% of hospital's base DRG claims. These reductions apply to ALL of the hospital's Medicare cases, not just those that were readmitted.



Note: Two new quality measures added in FY 2015; one added FY 2017. Source: CMS

CMS measures hospital performance over a three-year period. For example, CMS will use readmissions data from 2014 – 2017 to calculate payment adjustments (penalties) for fiscal year 2019.

Applies to most acute care hospitals except for: critical access, psychiatric, rehabilitation, long-term care, children's, PPS-exempt cancer hospitals. Does not apply to hospitals in Maryland which are paid under a unique system operating under a federal waiver.

Value-Based Purchasing

Medicare bases a portion of its annual payment to hospitals on how well they meet a specific set of quality and cost standards.

- CMS evaluates hospital performance in several areas:

  - ✓ Heart attack
  - ✓ Heart failure
  - ✓ Pneumonia
  - ✓ Infections
  - ✓ Surgery complications
  - ✓ Hospital-acquired conditions
  - ✓ Spending: 3 days prior to admitting a patient through 30 days after discharge
  - ✓ Patient opinions about their treatment
  - ✓ Hip and knee replacement

- CMS assigns points for how well a hospital performs on quality/efficiency measures in all of these areas. Then it factors this into calculating payment adjustments for the hospitals.

<u>To fund the program</u>, CMS holds back 2% of all DRG payments annually. This percentage reduction applies to all DRG payments—not just those related to the conditions covered by the quality measures.

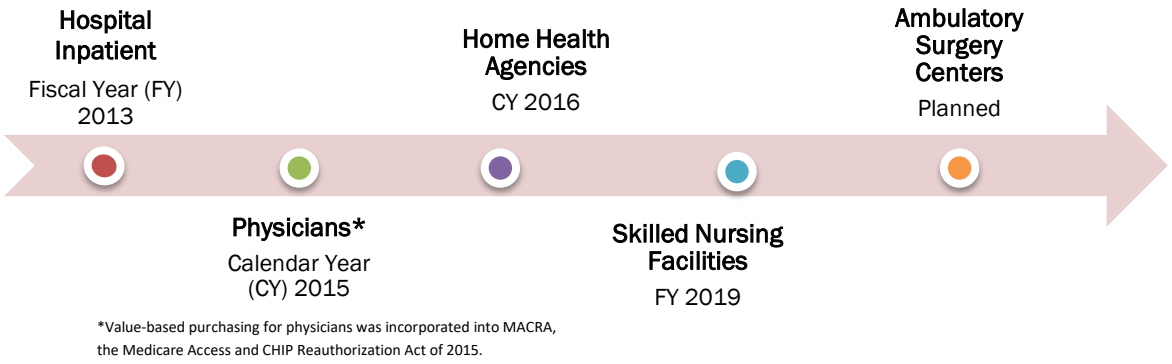
<u>CMS uses the funds for bonuses</u>: CMS then uses this money to reward hospitals that perform well.

The estimated reduction in DRG payments/bonus pool amount in FY 2019: $1.9 billion.

- Payment for Quality Reporting: Medicare requires providers to report their performance regularly on a variety of quality measures and metrics. If providers fail to do such reporting or do so poorly, Medicare also imposes a financial penalty. For hospitals, that means their annual market basket update is reduced by 2%.

More Medicare VBP Programs and Implementation Dates

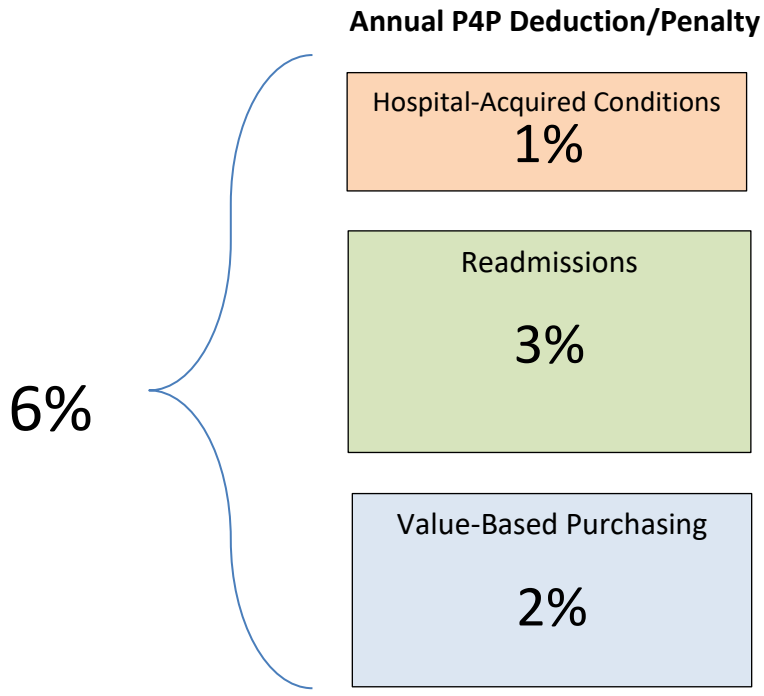
Value-Based Purchasing was initiated in FY 2013 and applied only to inpatient hospital care. Since then, it has expanded to other delivery sites.



*Value-based purchasing for physicians was incorporated into MACRA, the Medicare Access and CHIP Reauthorization Act of 2015.

Pay-for-Performance Penalties Add Up

If a hospital performs poorly on all P4P programs, it can face a sizeable reduction in DRG payments.



For more information, contact Lucy McDonough at lucy.mcdonough@philips.com