Applying the Commission’s principles for measuring quality: Hospital quality incentives

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Overview

- Issues with current programs
- MedPAC’s hospital value incentive program (HVIP) design
- HVIP modeling analysis
- Discussion
Issues with current hospital quality payment programs

- Contain too many, overlapping programs
- Rely on condition-specific readmission and mortality measures as opposed to all-condition measures which are more appropriate and accurate
- 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

Eliminate programs:
- Inpatient Quality Reporting Program (IQR)
- Hospital-Acquired Condition Reduction Program (HACRP)

Hospital Value Incentive Program (HVIP)
- Include four outcome, patient experience and value measures
  - Readmissions
  - Mortality
  - Spending (MSPB)
  - Overall patient experience
- Set clear, absolute and prospective performance targets
- Account for social risk factors by directly adjusting payment through “peer grouping”
- Budget neutral to current programs
- Continue public reporting
Benefits of moving to all-condition measures

- Improved accuracy
  - 92 percent of inpatient prospective payment system (IPPS) hospitals have over 1,000 discharges over 3 years
  - Stronger incentives for small hospitals to improve

- Balance incentives across measures
  - Readmissions: Reduced penalty per excess readmission, incentives applied to more conditions
  - Mortality: Incentives applied to more conditions
  - Could be weighted equally
HVIP scoring: Converting measure performance to HVIP points

- Each of the four measures is worth 10 points (40 total possible points)
- Each measure has a continuous performance-to-points scale (from 0 to 10 points)
  - Set points at the 2nd percentile of performance (0 points) to 98th percentile of performance (10 points)
  - Hospitals know in advance targets on the scale
### Illustrative continuous performance-to-HVIP points scale

<table>
<thead>
<tr>
<th>Points</th>
<th>Risk-adjusted readmissions rates</th>
<th>Risk-adjusted mortality rates</th>
<th>Relative Medicare spending per beneficiary</th>
<th>Patient’s overall rating of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>20% or above</td>
<td>15% or above</td>
<td>1.16 or above</td>
<td>53% or below</td>
</tr>
<tr>
<td>2</td>
<td>18%</td>
<td>13%</td>
<td>1.09</td>
<td>60%</td>
</tr>
<tr>
<td>4</td>
<td><strong>16%</strong></td>
<td>11%</td>
<td>1.02</td>
<td>67%</td>
</tr>
<tr>
<td>6</td>
<td>14%</td>
<td><strong>9%</strong></td>
<td><strong>0.95</strong></td>
<td><strong>73%</strong></td>
</tr>
<tr>
<td>8</td>
<td>12%</td>
<td><strong>7%</strong></td>
<td>0.88</td>
<td>80%</td>
</tr>
<tr>
<td>10</td>
<td>10% or below</td>
<td>5% or below</td>
<td>0.82 or below</td>
<td>87% or above</td>
</tr>
</tbody>
</table>

Only a subset of points from 0 to 10 are shown. Highlighted values show a hypothetical hospital’s HVIP points.
HVIP scoring: Converting HVIP points to payment adjustments using peer grouping

- In quality payment programs, Medicare should take into account differences in provider populations through peer grouping
  - Each provider is being compared to other providers with a similar beneficiary mix
- Modeled HVIP scoring using 10 peer groups based on share of fully dual-eligible beneficiaries
- Each peer group has 2% of total base IPPS payments withhold; redistributed based on HVIP points
### Illustrative conversion of HVIP points to payment adjustments within a peer group

<table>
<thead>
<tr>
<th></th>
<th>Hospital 1 (500 discharges)</th>
<th>Hospital 2 (5,000 discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVIP points</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>Total base IPPS payments</td>
<td>$5,000,000</td>
<td>$60,000,000</td>
</tr>
<tr>
<td>2% withhold of IPPS payments</td>
<td>$100,000</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>Total HVIP bonus pool for peer group</td>
<td></td>
<td>$1,300,000</td>
</tr>
<tr>
<td>Percentage adjustment to payments per points</td>
<td></td>
<td>0.065% adjustment per point</td>
</tr>
<tr>
<td>Hospital HVIP-based adjustment</td>
<td>2.60% ($130,000)</td>
<td>1.95% ($1,170,000)</td>
</tr>
<tr>
<td>Net HVIP adjustment</td>
<td>$30,000</td>
<td>– $30,000</td>
</tr>
</tbody>
</table>
### Illustrative HVIP payment adjustments by hospital peer groups

<table>
<thead>
<tr>
<th>Peer group</th>
<th>Range of net HVIP payment adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (lowest-share of fully dual-eligibles)</td>
<td>-1.1% to + 1.1%</td>
</tr>
<tr>
<td>3</td>
<td>-1.2 to + 1.0</td>
</tr>
<tr>
<td>6</td>
<td>-1.1 to + 1.0</td>
</tr>
<tr>
<td>10 (highest-share of fully dual-eligibles)</td>
<td>-1.3 to + 1.6</td>
</tr>
</tbody>
</table>

Only a subset of peer groups are shown. Each peer group has a 2 percent withhold of total base IPPS payments.
Comparison of HVIP to current hospital quality programs

- Most hospitals that receive rewards (penalties) under the current programs would continue to receive rewards (penalties)
- Comparing quartiles of performance in the current program to HVIP – about 75% of hospitals were in the same or within one quartile of performance
Illustrative payment adjustments relative to average by hospital peer groups

Note: We included a budget neutrality adjustment to make the current programs and HVIP comparable.
Summary

- HVIP is simpler than the current four, overlapping programs, and promotes the coordination of care.
- In line with the Commission’s principles, the HVIP we modeled incorporates:
  - Small set of outcome, patient experience and value measures
  - Clear, absolute, and prospectively set targets using a continuous performance-to-points scale
  - Converts those points to payment adjustments relative to peer groups
- HVIP appears to reduce the differences in payment adjustments between groups of providers serving populations with different social risk factors.
Discussion

- Clarifying questions
- Feedback on
  - Design
  - Other analysis?
  - Future recommendations?