Public reporting of 2013 quality measures on the Physician Compare and Hospital Compare Websites

Overview

The Centers for Medicare & Medicaid Services (CMS) has added new quality data to the Physician Compare website. Additionally, CMS has updated quality measures on the Hospital Compare website and released data on new measures. These websites are part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making.

Physician Compare

The first quality measures were added to Physician Compare in February 2014. Since then, the number of groups reporting quality data through the Physician Quality Reporting System (PQRS) has doubled. Physician Compare is a website, authorized by the Affordable Care Act, to help consumers make informed choices about the health care they receive from Medicare physicians and other health care professionals. Publicly reporting this quality information on the Physician Compare website will help further that goal.

Public reporting of 2013 quality measures on the Physician Compare website

Today, CMS posted the publicly reported 2013 PQRS Group Practice Reporting Option (GPRO) measures for 139 group practices and 214 Shared Savings Program Accountable Care Organizations (ACOs) and 23 Pioneer ACOs. The specific measures being reported are:

- Controlling blood sugar levels in patients with diabetes (GPRO DM-15: Diabetes Mellitus: Hemoglobin A1c Control (<8%)).
- Controlling blood pressure in patients with diabetes (GPRO DM-13: Diabetes Mellitus: Blood Pressure Control in Patients with Diabetes).
- Prescribing aspirin to patients with diabetes and heart disease (GPRO DM-16: Diabetes Mellitus: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease).
- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions (GPRO CAD-7: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)).

To make the information user-friendly for consumers, performance scores on each measure for the group practices are displayed on Physician Compare as stars followed by a percent, with each star representing 20 percent. The Physician Compare stars represent how each group practice performs on any given quality measure and provide a graphical way of looking at the data. The stars convey quality information, so more stars are better. If a group practice scores 80

percent on a measure, four fully-filled stars will be shown followed by "80%." This indicates the practice performed very well in the category. The stars on Physician Compare are not used as a rating or ranking system because they do not serve to benchmark group practices against one another. You can visit an example group practice profile.

With this release in December 2014, CMS has now added four patient experience of care measures for ACOs. These are survey measures modeled on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for clinicians and group practices. These surveys ask patients about their experiences with their health care professionals. The surveys focus on matters that patients themselves say are important to them such as how well their doctors communicate and getting timely care, appointments, and information.

Currently, users have the ability to compare the general information for up to three group practices on Physician Compare. This includes names, addresses, distance from the search location, specialty, Medicare assignment, and affiliated health care professionals. However, users are not able to do side-by-side comparisons of measure data at this time. The ability to compare ACOs is also not available at this time. Consumers will have the ability to compare group practices and ACOs to one another in the future as more data are available.

Looking ahead, CMS plans to significantly expand the number of quality measures available for public reporting on Physician Compare. In late 2015, CMS will post quality measures for groups of all sizes and a subset of quality measures for individual physicians.

For a list of all of the group practices that currently have quality data, please view the Physician Compare Downloadable Database.

For more information on Physician Compare, visit: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/.

Hospital Compare

Hospital Compare provides information on hospital performance on a wide variety of quality measures, including how often the hospital provides recommended care, certain measures of healthcare infections, and how recently discharged patients responded to a national survey about their hospital experience. Public reporting of hospital performance information empowers consumers by providing information they can use to make more informed health care decisions, encourages providers to improve quality, and drives overall health system improvement.

Hospital Compare currently provides information on over 4,000 hospitals, updated on a quarterly basis. This includes measures from CMS' Hospital Inpatient and Outpatient Quality Reporting Programs and Hospital Value-Based Purchasing Program. The measures being reported for the first time are:

- Patient Experience of Care
  - Care transition survey measure
- Timely and Effective Care
  - Healthcare workers given influenza vaccination (Healthcare Provider Influenza Measure)
  - Heart surgery patients whose blood sugar (blood glucose) is kept under good control 18-24 hours after surgery (SCIP-Inf-4)
- Readmissions, Complications, & Deaths
  - 30-day risk-standardized mortality and readmission rates for COPD and stroke
- Payment and Value of Care

    - Payment for heart attack patients (AMI 30-day Episode of Care Payment)
- PPS-Exempt Cancer Hospital Quality Reporting Program
    - Adjuvant chemotherapy colon cancer
    - Combination chemotherapy breast cancer

The health care worker influenza measure was developed by the Centers for Disease Control and Prevention (CDC). This measure tracks the percentage of health care workers who have received the flu vaccine each flu season. It is recommended that all health care facilities provide the flu vaccine to their staff because doing so has been found to reduce the risk of flu illness, medical visits, antibiotic use, and flu-related deaths.

The Care Transition measure will also be reported for the first time today. The HCAHPS Survey is a standardized survey to measure patients' perspectives of their hospital care. The HCAHPS measures were created to publicly report patients' perspectives on their hospital care. The HCAHPS Care Transition Measure is a composite measure that captures how patients experience their care transition after their stay in an acute care setting. The Care Transition Measure reports how well patients understood the type of care they would need after leaving the hospital.

In addition to the new measures described above, the following new measures will be reported as part of Medicare hospital pay-for-performance programs:

- Hospital Value-Based Purchasing
    - Medicare Spending per Beneficiary (Efficiency domain)
    - Central line-associated bloodstream infection (CLABSI)
    - AHRQ PSI-90 composite measure
- Hospital Acquired Condition (HAC) Reduction Program
    - Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure
    - Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) measure
    - CDC NHSN Catheter-Associated Urinary Tract Infection (CAUTI) measure
- Hospital Readmission Reduction Program
    - Rate of complications for hip/knee replacement patients (30-day risk standardized readmission following elective, primary total hip and/or total knee replacement)
    - Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients (30-day risk standardized readmission for COPD)

For more information on Hospital Compare, please visit: http://www.medicare.gov/hospitalcompare/search.html.

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Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program

Hospital-Acquired Condition (HAC) Reduction Program

Program Overview

The Hospital-Acquired Condition (HAC) Reduction Program is the newest effort under the Affordable Care Act that builds on the progress of reducing hospital acquired conditions achieved through the existing HAC program

established under the Deficit Reduction Act (DRA) of 2005. The DRA HAC program currently saves the Medicare program approximately $30 million annually. These savings are the result of not providing additional Medicare payment for treatment of certain reasonably preventable conditions when those conditions are acquired after the beneficiary has been admitted to the hospital.

The HAC Reduction Program uses public reporting and financial incentives to encourage Inpatient Prospective Payment System hospitals to reduce HACs and improve patient safety. The HACs, which are specified in rulemaking by the Centers for Medicare & Medicaid Services (CMS) each year, are a group of reasonably preventable conditions, including infections, that patients did not have upon admission to a hospital, but which developed during the hospital stay. The HAC Reduction Program builds on the Administration's efforts to achieve better patient outcomes while slowing health care cost growth.

Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from one to 10. The higher a hospital's Total HAC Score, the less well the hospital performed under the HAC Reduction Program. Effective beginning FY 2015, the law requires a payment reduction of one percent for all discharges for those hospitals that rank in the quartile of hospitals with the highest Total HAC Scores.

Fiscal Year 2015 Results

Results for the fiscal year (FY) 2015 HAC Reduction Program have been calculated and, pursuant to the law, hospitals have been given a chance to review their preliminary results and request a recalculation of their scores if they believe an error in score calculation has occurred.

Hospital specific HAC Reduction Program scores are being posted on the Hospital Compare website. In FY 2015, approximately 724 hospitals will have their payments reduced by one percent under the HAC Reduction Program. Payment for hospital discharges occurring on or after October, 1, 2014, are seeing a reduction.

Computing the Total HAC Score

The Total HAC Score is composed of two domains: patient safety (Domain 1) and healthcare-associated infections (Domain 2). For the FY 2015 HAC Reduction Program, Domain 1 included the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 composite measure, and Domain 2 included the Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) measures.

CMS based its decision on which measures to include in the HAC Reduction Program on currently available quality measures that are risk adjusted and reflective of hospital performance. Endorsement by the National Quality Forum (NQF) and support from the NQF-convened Measures Application Partnership (MAP) are also taken into account. NQF, a non-profit, nonpartisan, membership-based organization, uses a formal process for evaluating and endorsing quality measures. The MAP makes recommendations on measures most appropriate for public reporting, performance-based payment, and other uses across federal programs. The MAP includes representatives of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. Both the NQF endorsement and MAP recommendation processes involve public comment. All the measures finalized for inclusion in the HAC Reduction Program are NQF endorsed and were recommended for inclusion in the Program by the MAP. They were also included in the FY 2014 and 2015 proposed rules for additional public comments.

Moving Forward

CMS is currently evaluating several aspects of the HAC Reduction Program, including identification of new, potentially suitable measures to fill HAC performance gaps and examination of the scoring methodology to determine if modifications are needed. Public comments received during rulemaking have helped to inform this process of improving the HAC Reduction Program. In addition, CMS anticipates receiving additional valuable input during the MAP meetings in December 2014 and January 2015.

CMS' contractor, Yale/CORE, convened a Technical Expert Panel which is synthesizing input from a wide variety of experts with diverse perspectives on potential revisions to the scoring methodology and on potential new measures to propose for inclusion in the program. A summary of the Technical Expert Panel deliberations was made widely

available in November, and stakeholders were given an opportunity for public comment.

Additional Information
Additional information about the HAC Reduction Program is available on Quality Net: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166

Hospital Value-Based Purchasing Program

Program Overview
The Hospital Value-Based Purchasing (VBP) Program, which is authorized by the Affordable Care Act, adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care they furnish to patients. For FY 2015, as directed by the law, the CMS increased the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, from 1.25 to 1.5 percent of the base operating DRG payment amounts to all participating hospitals. CMS estimates that the total amount available for value-based incentive payments in FY 2015 will be approximately $1.4 billion.

The Hospital VBP Program provides a useful snapshot of how hospitals are performing on important quality indicators of patient care, quality, efficiency, and well-being and is one of many Affordable Care Act programs Medicare is implementing to pay for quality instead of quantity. The domains for FY 2015 were:

- Clinical Process of Care: 20 percent
- Patient Experience of Care (HCAHPS survey): 30 percent
- Outcome: (hospital mortality measures for acute myocardial infarction, heart failure, and pneumonia, and the central line-associated bloodstream infection measure): 30 percent
- Efficiency: (Medicare Spending per Beneficiary measure gauges efficiency by calculating total cost to Medicare for hospitals' episodes: 20 percent

The Hospital VBP Program is part of CMS' long-standing effort to structure Medicare's payment systems to improve healthcare quality, including the quality of care for hospital inpatients. The program is in its third year of value-based purchasing for the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,000 hospitals across the country. Hospitals are now paid for inpatient acute care services based on the *quality* of care, not just the *quantity* of the services they provide.

The program has been increasing the number of quality domains and measures it uses to evaluate performance, with the goal of including a broader, richer set of measures over time and aligning with the National Quality Strategy (NQS). CMS believes that the program's benefits will be seen in improved patient outcomes, safety, and in the patient's experience of care.

Fiscal Year 2015 Results
CMS has posted Hospital Value-Based Purchasing incentive payment adjustment factors for fiscal year 2015 on the CMS website. The Hospital VBP Program adjustment factors are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html.

Depending on how well hospitals measured up to their peers on important health-care quality measures during a prior performance period, and on how much they improved over their own historical performance, they will be paid more or less for each Medicare fee-for-service discharge in fiscal year 2015 than they would have been paid in the absence of this program.

Hospitals excluded from the Hospital VBP Program in FY 2015 will not be included in the table containing the

payment adjustment factors. Hospitals that are excluded from the Hospital Value-Based Purchasing Program do not incur the reduction of 1.5 percent and are not eligible to receive additional incentives.

Due to their desire to improve their quality of care, hospitals around the country are tracking their performance on Hospital Value-Based Purchasing measures via external performance dashboards that allow the continuous monitoring of their care provided and, in many cases, an estimated rate of incentive payment adjustment. This type of improvement focus should benefit patients.

The number of hospitals that will experience a positive change in their base operating diagnosis-related group (DRG) payments in fiscal year 2015 is slightly higher than the number of hospitals that will experience a negative change. In fiscal year 2015, about half of the hospitals see a small change in their base operating DRG payments (between -0.3 and 0.3 percent) – a reversal from last year.

Computing the VBP Score

The Hospital VBP Program is funded through a reduction from participating hospitals' base operating DRG payments for the applicable fiscal year. The payment reductions are redistributed to hospitals as incentive payments, based on their Total Performance Scores (TPS), as required by statute. The actual amount earned by each hospital will depend on its TPS, the hospital's value-based incentive payment percentage, and on the total amount available for value-based incentive payments. A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year. This means that the hospital could see an increase, a decrease, or no change to its Medicare payments for the applicable fiscal year.

The estimated amount of base operating DRG payment amount reductions for FY 2015 and the amount available for value-based incentive payments for FY 2015 discharges is approximately $1.4 billion.

In FY 2015, hospitals' total performance scores were based on four domains: clinical process of care, patient experience of care, outcome, and a new efficiency domain.

Hospitals' TPSs were subject to minimum case and measure requirements and they had to have a domain score for at least two of the four domains, in order to have a TPS calculated. Hospitals that do not meet the minimum requirements do not have their payments adjusted in the corresponding fiscal year. For every measure, each of the hospitals participating in the Hospital Value-Based Purchasing Program receives the higher of its improvement score or its achievement score.

New Program Requirements

The FY 2017 measure set will add two new Safety measures and one new Clinical Care - Process measure, re-adopt the current version of the CLABSI measure, and remove six "topped-out" clinical process measures. Over 78 percent of the measures in the Hospital VBP Program will assess health outcomes, patient experience and cost.

CMS will adopt two new outcome measures for the new Safety domain: hospital-onset methicillin-resistant Staphylococcus aureus (MRSA) bacteremia and Clostridium difficile infection; and a Clinical Care - Process measure: early elective deliveries (PC-01).

FY 2017 Domain Weighting

CMS has finalized new quality domains based on the National Quality Strategy (NQS) and domain weighting for FY 2017. Due to the large number of "topped out" measures that CMS is removing from the FY 2017 measure set, the finalized FY 2017 domain weighting for hospitals that receive a score on all domains reduces the weight of the Clinical Care – Process subdomain to 5 percent and increases the weight of the Safety domain to 20 percent.

FY 2019/2020 Measure

CMS has adopted one new hospital-level risk-standardized complication rate following elective hip and knee arthroplasty measure with a 30-month performance period for FY 2019 and a 36-month performance period for FY 2020.

Moving Forward

As CMS moves forward with a regulatory framework that more closely links patient outcomes and treatment costs to value-based hospital payment, it's important to remember that the Hospital Value-Based Purchasing program not only aims for quality gains on paper, it also aims to promote the growth of a culture that is focused on the needs of patients.

Value-based purchasing in Medicare continues to move ahead, improving the way that health care is delivered to people with Medicare now and helping create a health care system that will ensure quality care for generations to come.

Additional Information

To see the FY 2015 value-based incentive payment adjustment factors, please visit: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/.

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