

# Medicare Readmission Reduction and Hospital Acquired Condition Programs

## Overview

Michigan Health and Hospital Association

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# Today's Objectives

- Overview of Medicare Readmission Reduction and Hospital Acquired Condition Programs
- Review Methodologies
- Review Michigan's performance in the two programs
- Review RRP and HAC Analyses

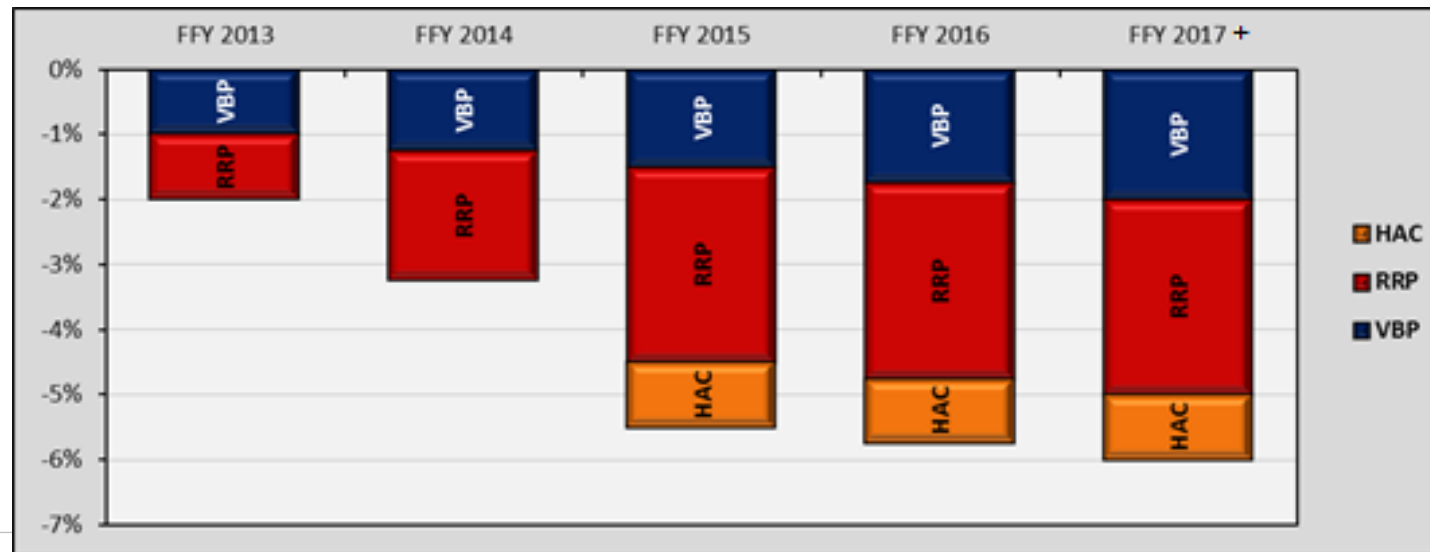
# Medicare Quality Based Payment Reform (QBPR) Programs

- Mandated by the ACA of 2010
  - VBP Program (redistributive w/ winners and losers)
  - Readmissions Reduction Program (remain whole or lose)
  - HAC Reduction Program (remain whole or lose)
- National pay-for-performance programs
- Most acute care hospitals must participate; CAHs excluded
- Program rules, measures, and methodologies adopted well in advance (through 2027)



# Medicare Quality Programs

- Payment adjustments based on facility-specific performance compared to national standards
- Performance metrics are determined using historical data
- Program components change every year



# FFY 2024 Quality Program Measure Populations

- **Value-Based Purchasing (VBP)**
  - All patients
    - Safety, Person and Community Engagement
  - Medicare FFS patients only
    - Clinical Outcomes, Efficiency and Cost Reduction
- **Readmissions Reduction Program (RRP)**
  - Medicare FFS patients only
- **Hospital Acquired Conditions (HAC)**
  - All patients
    - CAUTI, CLABSI, C-diff., MRSA, SSI Colon, SSI Abdominal Hysterectomy
  - Medicare FFS patients only
    - PSI-90



# Medicare Readmission Reduction Program (RRP)



- Program became effective FFY 2013 (October 1, 2012)
- Penalizes hospitals for exceeding expected readmission rates
  - Expected rates based on national performance levels
- Program expands over time with addition of new conditions
- Penalty capped at 3% for 2015 and thereafter
  - 1% in FFY 2013;
  - 2% in FFY 2014;
  - 3% in FFY 2015+
- Measures are established in advance through the IPPS rule



# RRP Program Timeframes

2018					2019					2020					2021					2022					2023					2024					2025																																																												
J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
					<b>FFY 2023 Program Performance Period (All Conditions except PN)</b>					Excluded <sup>#</sup>					<b>FFY 2023 Program (All Conditions except PN)</b>										<b>FFY 2023 Program Payment Adjustment</b>																																																																						
					<b>FFY 2024 Program</b>					Excluded <sup>#</sup>					<b>FFY 2024 Program Performance Period (All Conditions)</b>										<b>FFY 2024 Program Payment Adjustment</b>																																																																						
															<b>FFY 2025 Program Performance Period (All Conditions)</b>															<b>FFY 2025 Program Payment Adjustment</b>																																																																	

<sup>#</sup>These performance periods are impacted by the extraordinary circumstances exception granted by CMS in response to the PHE so no claims data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for RRP.

# RRP Methodology

- Excess readmission ratios are calculated for multiple condition areas

Measure	FFY 2013 Program	FFY 2014 Program	FFY 2015 Program	FFY 2016 Program	FFY 2017+ Program
AMI	X	X	X	X	X
HF	X	X	X	X	X
PN	X	X	X	X	X*
COPD			X	X	X
THA/TKA			X	X	X
CABG					X

\*expanded to include aspiration PN and sepsis with a secondary diagnosis of PN

- Improvement is not recognized
- Certain planned readmissions are not counted
- No offsets between categories
- PN was not included in FFY 2023 due to COVID-19
- Socio-Demographic Status (SDS) adjustment based on percent of full-benefit dual eligible patients



# RRP Methodology – FFY 2024 SDS Adjustment

- Groups based on ratio of full-benefit dual eligible relative to total Medicare patients:  
$$\frac{\# \text{ Full-benefit Dual Status}}{\# \text{ Medicare Patients}}$$
- An individual is counted as a full-benefit dual patient if the patient was identified as such for the month he/she was discharged from the hospital
  - identified using the State Medicare Modernization Act (MMA) file of dual eligibility
- Data period for identifying patients is the same 3-year period as the performance period
  - i.e. July 1, 2019 – June 30, 2022 for FFY 2024
- Total number of Medicare patients is all Medicare FFS and Medicare Advantage stays using MedPAR files
- Hospitals are grouped into national quintiles based on full-benefit dual eligible ratio and compared to hospitals within their quintile

# RRP Methodology

- Step 1: Place hospital into quintile

$$\frac{\text{\# Full-benefit Dual Status Patients}}{\text{\# Medicare Patients}} = \text{Full - benefit Dual Eligible Ratio}$$

$$\frac{14,322}{29,453} = \text{Full - benefit Dual Eligible Ratio}$$

$$48.6\% = \text{Full - benefit Dual Eligible Ratio}$$

Ratio of 48.6% puts this hospital in quintile 3

- Quintile placement on a national level
- Placement will change from year to year based on data period used and ratios of other hospitals
- Quintile 5 is highest, meaning the higher full-benefit dual eligible ratios
- Quintile 1 is lowest, meaning the lowest full-benefit dual eligible ratios
- Hospitals in higher quintiles will have less stringent benchmarks
- Hospitals in lower quintiles will have more stringent benchmarks

# RRP Methodology (con't)

- **Step 2: Calculate excess readmission ratios for each condition**

(subject to minimum case counts requirements)

$$\frac{\text{Predicted AMI Readmission Rate}}{\text{Expected AMI Readmission Rate}} = \text{AMI Excess Ratio}$$

$$\frac{20.300 \%}{19.459 \%} = \text{AMI Excess Ratio}$$

$$1.0432 = \text{AMI Excess Ratio}$$

- Predicted readmissions = number of unplanned readmissions predicted for a hospital based on hospital's performance
- Expected readmission = expected U.S. readmission rate for each hospital's patient mix
- Ratio less than quintile median excess ratio
  - Lower than expected readmission rate
  - Better quality
- Ratio greater than quintile median excess ratio
  - Higher than expected readmission rate
  - Lower quality
  - Penalty applies

# RRP Methodology (con't)

- Step 3: Calculate total excess payments for each condition

Total Payment for AMI Procedures × (**Median Quintile Excess Ratio** – **AMI Excess Ratio**) = **AMI Excess Dollars**

Historically, excess ratio was compared to a “1”  $\$6,000,000 \times (1.0233 - 1.0432) = \text{AMI Excess Dollars}$   
 $\$119,400 = \text{AMI Excess Dollars}$

- Step 4: Calculate total excess payments for all conditions

**AMI Excess Payments** + **HF Excess Payments** + **PN Excess Payments** + **COPD Excess Payments** +  
**THA TKA Excess Payments** + **CABG Excess Payments** = **Total Excess Dollars**

**\$119,400** + **\$0** + **\$0** + **\$0** + **\$0** + **\$0** + **\$0** = **Total Excess Dollars**

**\$119,400** = **Total Excess Dollars**

- Excess Ratios are multiplied by revenue in each condition area to find excess readmission revenue by condition
  - Sum of all conditions excess revenue = total excess readmission dollars
  - Revenue = exposure
  - More conditions = More exposure

# RRP Methodology (con't)

- **Step 5: Calculate Readmissions Adjustment factor** (capped at .97, or 3%, for FFY 2015+)

$$\left[ 1 - \text{BN Adjuster} \times \frac{\text{Total Excess Dollars}}{\text{3 yr Total Medicare IPPS Operating Revenue}} \right] = \text{Readmissions Adj. Factor}$$

$$\left[ 1 - 0.99 \times \frac{\$119,400}{\$50,000,000} \right] = \text{Readmissions Adjustment Factor}$$

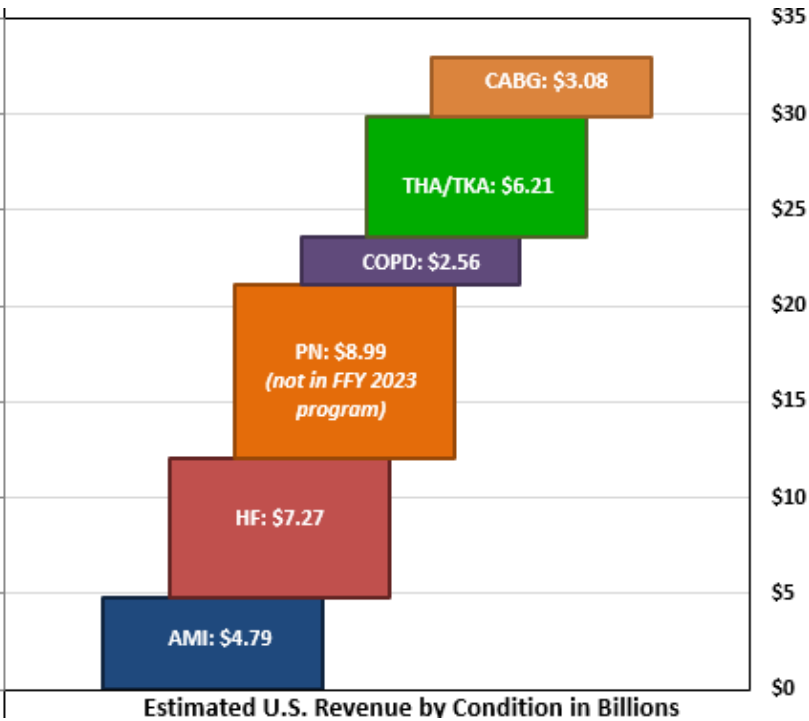
0.9976 = Readmissions Adjustment Factor

(applied on a per-claim basis)

-0.24% cut

- Total excess readmission revenue is used to calculate adjustment factors.
- The excess revenue is not your impact.
- Payments are adjusted on a per-claim basis to all Medicare FFS cases (not just RRP cases)
- Although the SDS adjustment is budget neutral nationally, there will be winners and losers within each quintile.

# RRP Trends



- Continually evolving
- As measures are added, exposure increases and hospitals are more likely to receive penalties

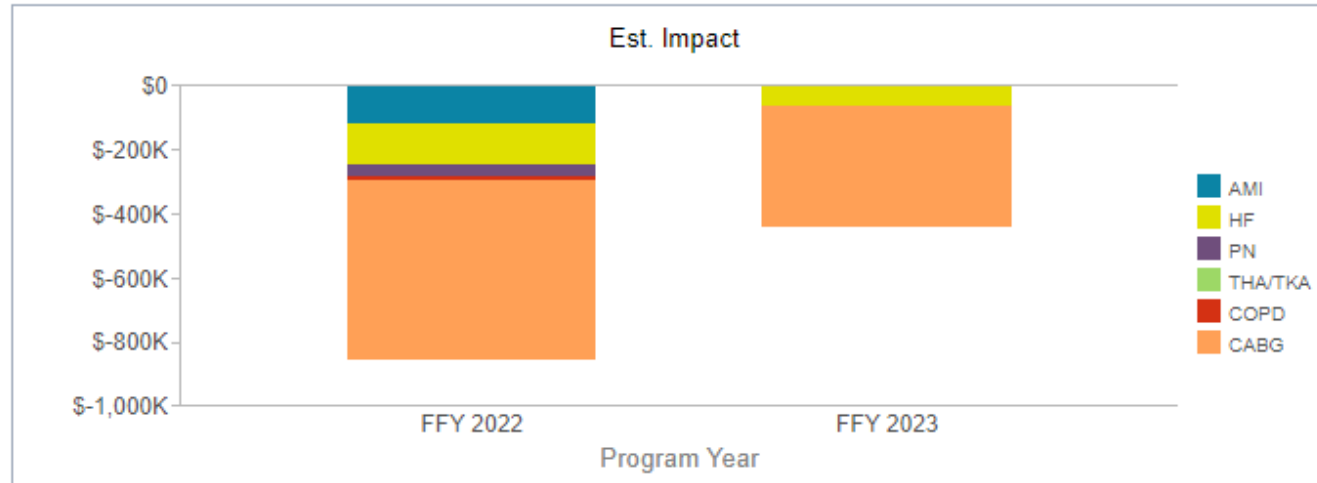
Adjustment Factor	Percent Cut	2020	2021	2022	2023
No Payment Penalty	0%	17.5%	17.4%	18.0%	25.0%
0.9951 to 0.9999	-0.01% to -0.5%	42.5%	42.9%	44.5%	52.9%
0.9901 to 0.9950	-0.5% to -0.999%	18.9%	19.9%	19.7%	14.2%
0.9851 to 0.9900	-1.0% to -1.499%	10.6%	9.7%	9.4%	4.7%
0.9801 to 0.9850	-1.5% to -1.999%	4.8%	5.0%	4.0%	1.4%
0.9751 to 0.9800	-2.0% to -2.499%	2.7%	2.8%	2.2%	0.7%
0.9701 to 0.9750	-2.5% to -2.999%	1.2%	1.1%	0.9%	0.3%
0.97	-3.0%	1.8%	1.2%	1.3%	0.8%

# RRP Performance Scorecard

Actual FFY 2022 Performance					Actual FFY 2023 Performance				
Actual Adj. Factor	Actual % Impact	Est. Revenue Subject to Adj.	Est. Impact	Max Penalty (3.0%)	Actual Adj. Factor	Actual % Impact	Est. Revenue Subject to Adj.	Est. Impact	Max Penalty (3.0%)
0.9700	-3.00%	\$28,432,300	(\$853,000)	(\$853,000)	0.9852	↑ -1.48%	\$29,612,500	(\$438,300)	(\$888,400)
National Budget Neutrality Modifier	% Full-Benefit Dual Eligible	National Quintile	SDS Impact (Breakout)		National Budget Neutrality Modifier	% Full-Benefit Dual Eligible	National Quintile	SDS Impact (Breakout)	
0.9637	17.33%	2	(\$10,000)		0.9558	18.15%	2	\$10,000	

Condition Chart:

- Condition Revenue
- Est. Impact



Actual FFY 2022 Performance				Actual FFY 2023 Performance			
Condition	Condition Revenue	Est. Impact	Percent Impact	Condition	Condition Revenue	Est. Impact	Percent Impact
AMI	\$3,703,900	(\$118,100)	13.84%	AMI	\$2,937,000	\$0	0.00%
HF	\$3,355,500	(\$127,800)	14.99%	HF	\$2,311,500	(\$62,300)	14.21%
PN	\$4,168,600	(\$36,800)	4.31%	THA/TKA	\$153,100	\$0	0.00%
THA/TKA	\$177,000	\$0	0.00%	COPD	\$911,500	\$0	0.00%
COPD	\$1,130,500	(\$12,200)	1.43%	CABG	\$3,159,700	(\$376,000)	85.79%
CABG	\$4,185,700	(\$558,100)	65.43%				

# RRP Performance Scorecard (con't)

Condition:

- AMI
- CABG
- COPD
- HF
- PN
- THA/TKA



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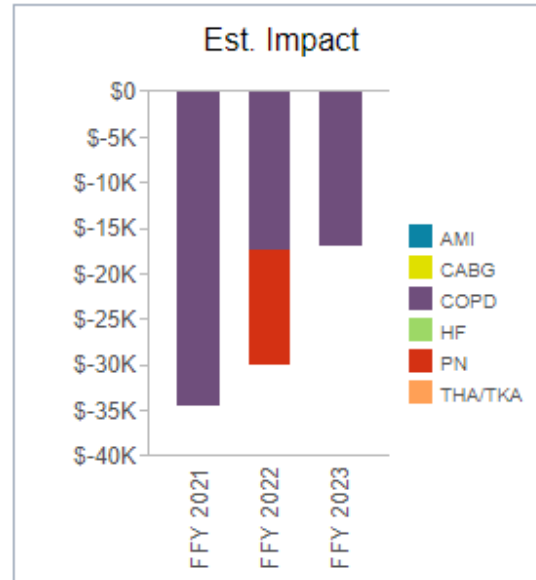
## Actual Performance: CABG

FFY Program	2022	2023
Eligible Discharges	142	114
DRG Ratio [A]	0.0466	0.0371
Excess Ratio [B]	1.4277	1.3519
Quintile Median [C]	0.9845	0.9931
Excess % [D = C - B]	0.4432	0.3587
Excess Amt. [E = A x D]	0.0206	0.0133
Total Excess Amt. [F = Sum(E)]	0.0316	0.0155
Excess % of Total [G = E/F]	65.43%	85.79%
Total Est. Impact [H]	(\$853,000)	(\$438,300)
Est. Impact by Condition [G x H]	(\$558,100)	(\$376,000)

An adjustment factor in blue indicates there would have been higher penalty if not capped at 3.0%



# Readmissions Reduction Program: Hospital Case Study

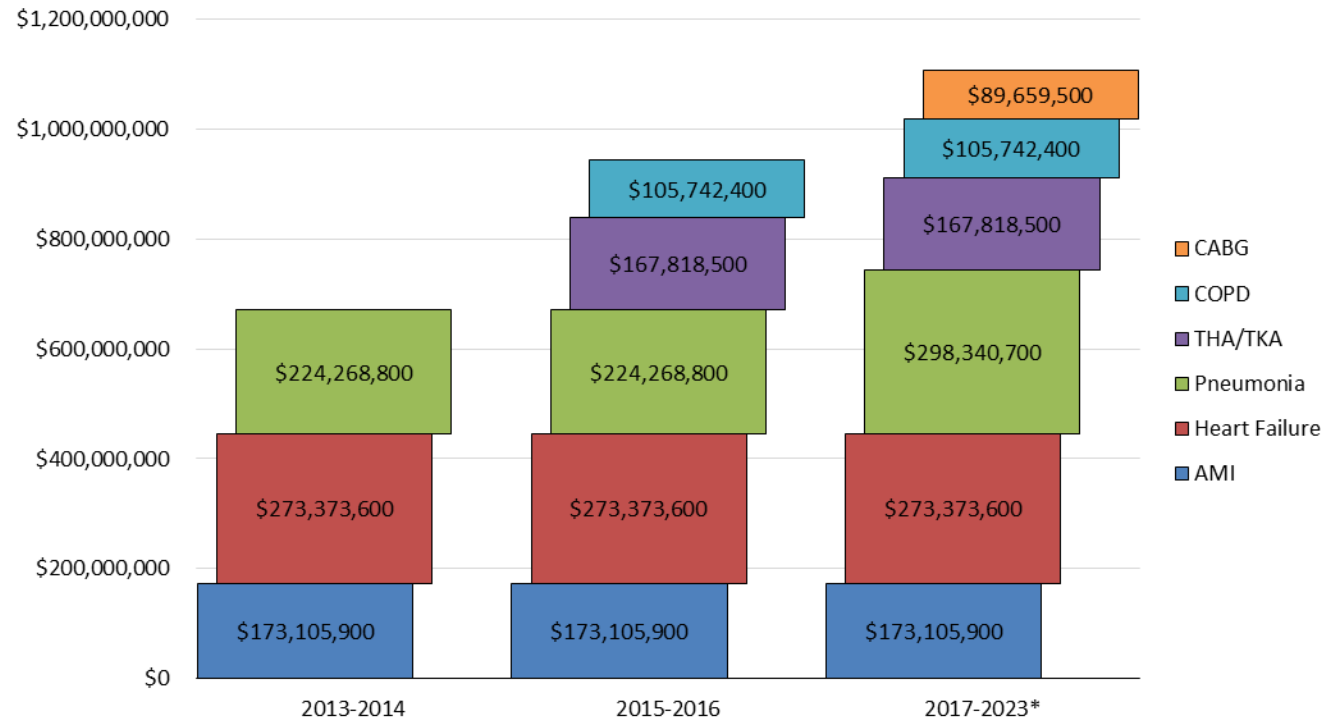


- Hospital had several excess ratios below 1 in 2022
- Hospital still has a negative impact of **(\$30,000)** in 2022 in part due to being in quintile 2 for the SDS adjustment and having more stringent benchmarks (less than 1)
- Hospitals in higher quintiles will typically be compared to less stringent benchmarks and hospitals in lower quintiles will generally be compared to more stringent benchmarks.

	2021		2022		2023	
	Excess Ratio	Median Excess Ratio	Excess Ratio	Median Excess Ratio	Excess Ratio	Median Excess Ratio
AMI	0.9184	0.9918	0.9880 ▲	0.9955	0.9870 ▼	0.9954
HF	0.9275	0.9899	0.8892 ▼	0.9927	0.9070 ▲	0.9927
PN	0.9418	0.9872	0.9977 ▲	0.9865	-	-
THA/TKA	0.8165	0.9941	0.8651 ▲	0.9944	0.9022 ▲	0.9923
COPD	1.0647	0.9942	1.0372 ▼	0.9941	1.0470 ▲	0.9949
CABG	0.9256	0.9942	0.9834 ▲	0.9845	0.9881 ▲	0.9931

Quintile Assignment	2	2	2
Final RRP Adjustment Factor	0.9988	0.9989	0.9994
<b>Estimated Annual Impact</b>	<b>(\$34,500)</b>	<b>(\$30,000) ▲</b>	<b>(\$17,000) ▲</b>

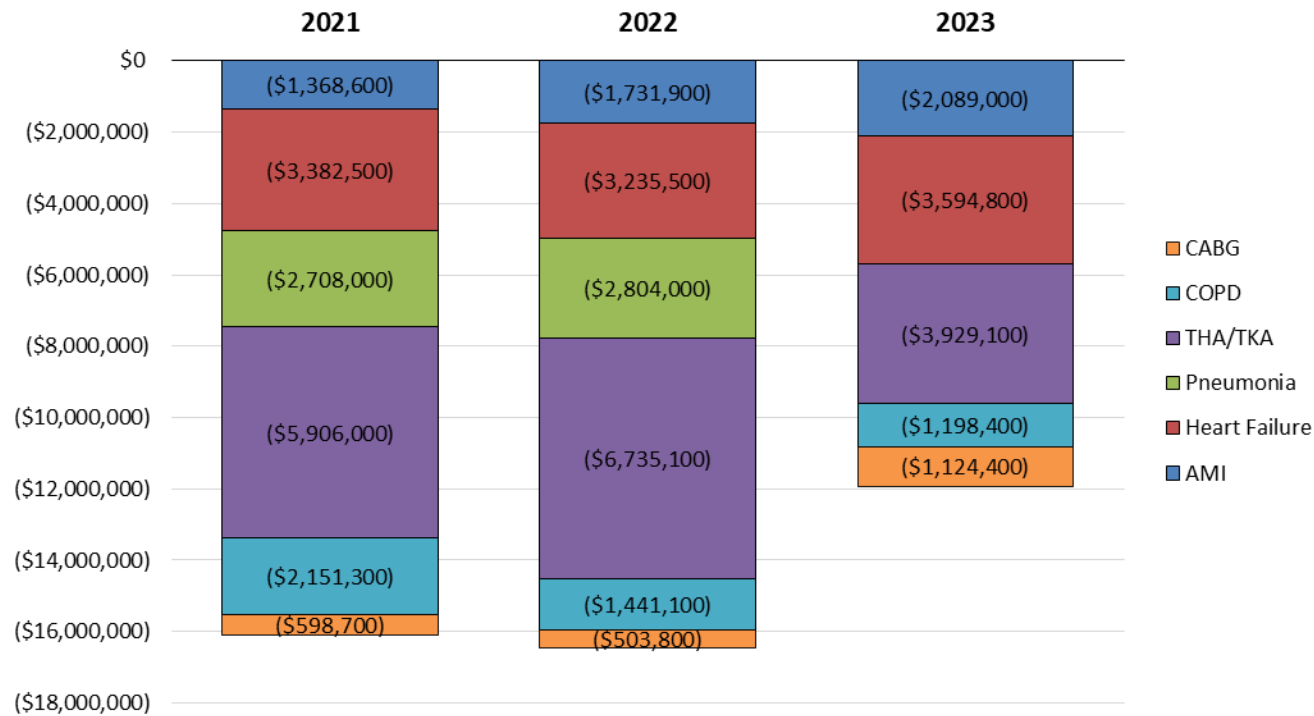
# MI's RRP Revenue by Condition



Condition/Procedure	2013-2014	2015-2016	2017-2023*
AMI	\$173,105,900	\$173,105,900	\$173,105,900
Heart Failure	\$273,373,600	\$273,373,600	\$273,373,600
Pneumonia	\$224,268,800	\$224,268,800	\$298,340,700
THA/TKA	N/A	\$167,818,500	\$167,818,500
COPD	N/A	\$105,742,400	\$105,742,400
CABG	N/A	N/A	\$89,659,500
<b>Total Program Exposure</b>	<b>\$670,748,300</b>	<b>\$944,309,200</b>	<b>\$1,108,040,600</b>
<b>Increase in Exposure</b>		<b>40.8%</b>	<b>17.3%</b>

\*no PN in FFY 2023 due to the measures association with COVID-19.

# MI's RRP Impact by Condition



Condition/Procedure	2021	2022	2023
AMI	(\$1,368,600)	(\$1,731,900)	(\$2,089,000)
Heart Failure	(\$3,382,500)	(\$3,235,500)	(\$3,594,800)
Pneumonia	(\$2,708,000)	(\$2,804,000)	N/A
THA/TKA	(\$5,906,000)	(\$6,735,100)	(\$3,929,100)
COPD	(\$2,151,300)	(\$1,441,100)	(\$1,198,400)
CABG	(\$598,700)	(\$503,800)	(\$1,124,400)
<b>Total Impact</b>	<b>(\$16,115,100)</b>	<b>(\$16,451,400)</b>	<b>(\$11,935,700)</b>

Eligible providers and their characteristics are based on the FFY 2023 IPPS Final Rule Correction Notice.

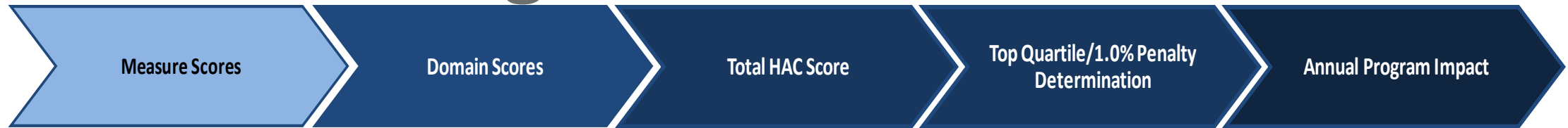
# MI's Readmission Rate Trends

		State Rates			
		2Q 2019 July 1, 2015 - June 30, 2018	2Q 2020 July 1, 2016 - June 30, 2019	2Q 2021 July 1, 2017 - Dec 1, 2019	2Q 2022* July 1, 2018 - Dec 1, 2020
Readmission Rates	READM_30_AMI: Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	15.6%	15.8% ▲	15.5% ▼	14.9% ▼
	READM_30_HF: Heart Failure (HF) 30-Day Readmission Rate	21.5%	21.9% ▲	22.0% ▲	21.3% ▼
	READM_30_PN: Pneumonia (PN) 30-Day Readmission Rate	16.6%	16.6% ▲	16.7% ▲	N/A
	READM_30_HIP_KNEE: Elective Total Hip/Knee Surgery (THA/TKA) 30-Day Readmission Rate	4.1%	4.1% ▲	4.1% ▲	4.1% ▼
	READM_30_COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	19.8%	20.0% ▲	20.0% ▼	20.1% ▲
	READM_30_CABG: Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	12.5%	12.0% ▼	11.9% ▼	11.5% ▼

# MI's Readmission Rank Trends

		State Rank			
		2Q 2019 July 1, 2015 - June 30, 2018	2Q 2020 July 1, 2016 - June 30, 2019	2Q 2021 July 1, 2017 - Dec 1, 2019	2Q 2022* July 1, 2018 - Dec 1, 2020
Readmission Ranks	READM_30_AMI: Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	29 of 51	22 of 51 ▼	22 of 51	25 of 51 ▲
	READM_30_HF: Heart Failure (HF) 30-Day Readmission Rate	32 of 51	31 of 51 ▼	32 of 51 ▲	30 of 51 ▼
	READM_30_PN: Pneumonia (PN) 30-Day Readmission Rate	27 of 51	26 of 51 ▼	26 of 51	N/A
	READM_30_HIP_KNEE: Elective Total Hip/Knee Surgery (THA/TKA) 30-Day Readmission Rate	44 of 51	47 of 51 ▲	46 of 51 ▼	40 of 51 ▼
	READM_30_COPD: Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	40 of 51	41 of 51 ▲	38 of 51 ▼	36 of 51 ▼
	READM_30_CABG: Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	26 of 51	12 of 51 ▼	11 of 51 ▼	19 of 51 ▲

# Medicare Hospital Acquired Condition (HAC) Reduction Program



- Program started FFY 2015 (October 1, 2014)
- Penalizes hospitals with the highest HAC rates
  - Rates are per 1,000 patients
  - Compared to all other eligible hospitals nationally
- **1% Penalty applied to all hospitals in the worst performing quartile**
  - 25% of hospitals will receive a penalty
  - Applied to Total Medicare FFS Inpatient Dollars
- Parameters set in IPPS rulemaking at least one year in advance
- Penalty is in addition to existing HAC DRG demotion policy

# HAC Program Timeframes

2019					2020					2021					2022					2023					2024					2025																																																					
J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
											Excluded <sup>#</sup>					FFY 2024: PSI-90 Performance Period										FFY 2024 Program Payment Adjustment																																																									
											Excluded <sup>#</sup>					FFY 2024: HAI Measures Performance Period																																																																			
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<sup>#</sup>These performance periods are impacted by CMS' adoption in the FFY 2022 IPPS Final Rule to suppress data from July 1, 2020 - December 31, 2020 due to the COVID-19 PHE for the HAC program. CMS also suppressed CY 2021 data for the HAI measures in the FFY 2023 IPPS Final Rule.

# HAC Reduction Program Methodology

- **HAC measures:**
  - PSI-90 Composite Measure, CAUTI and CLABSI, SSI (colon surgery and abdominal surgery), C-Diff and MRSA
- **Separate performance scores are calculated for each HAC measure**
  - Z-score
  - Based on national mean and standard deviation for all eligible hospitals
  - Improvement is not recognized
- **Average of all eligible measures are calculated to determine a total HAC score** (prior to FFY 2020, averages were calculated for two domains, then the domains were weighted together for a total HAC score)
- **Total HAC Score determines worst performing quartile of hospitals to receive 1% payment penalty**

# of HAI Measures with Scores	Weight applied to:	
	PSI 90	Each HAI
0	100%	N/A
1	50%	50%
2	33.3%	33.3%
3	25%	25%
4	20%	20%
5	16.7%	16.7%
Any number	N/A	100% (equally divided)

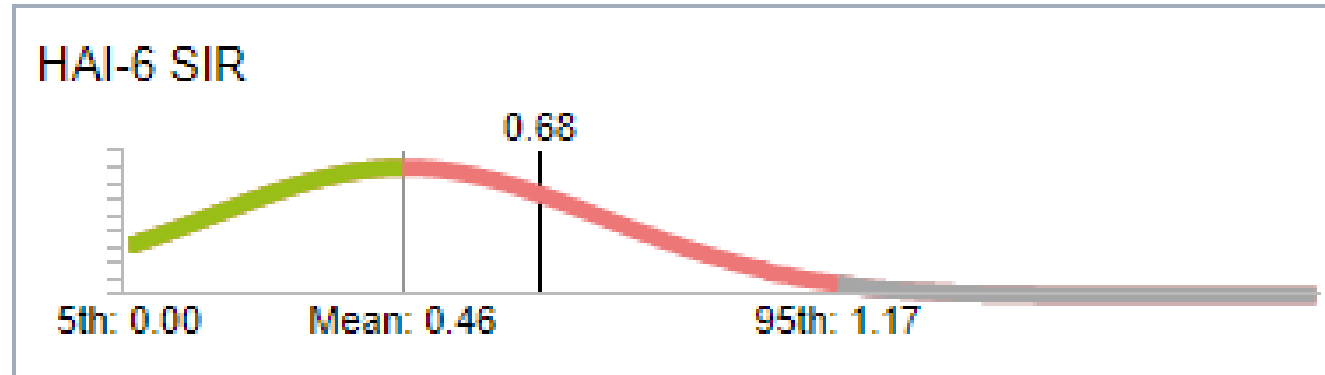


# HAC Reduction Program: Z-score Methodology

- HAC program evaluates hospitals based on a **Z-score**
  - Measure ratios are winsorized to remove effects of outliers (top and bottom 5%)
  - Represents a hospital's distance from the national average for a measure, in terms of units of standard deviation
    - A **POSTIVE** z-score is above the average, and reflects **POOR** performance
    - A **NEGATIVE** z-score is below the average, and reflects **GOOD** performance
    - Lower scores are better
  - Z-scores are averaged together to determine Total HAC Score

$$Z - \text{score} = \frac{\text{Hospital's Measure Performance} - \text{Mean Performance for All Hospitals}}{\text{Standard Deviation for All Hospitals}}$$

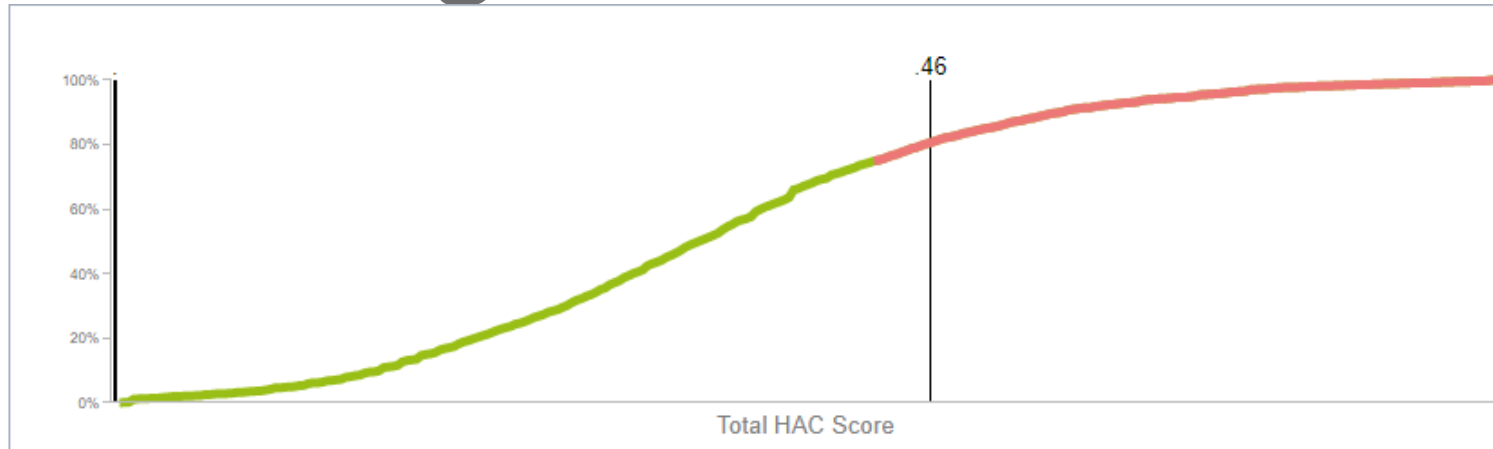
# HAC Reduction Program Measure Detail



## HAI-6: Clostridium difficile (C.diff.)

Numerator	Denominator	Standardized Infection Ratio (SIR)	Winsorized SIR	Winsorized National Mean	Winsorized National Std. Deviation	C.diff Z-Score
57.00	83.81	0.6800	0.6800	0.4631	0.3238	0.6698

# HAC Reduction Program Performance Scorecard



## Estimated FFY 2024 Performance

Total HAC Score	75th Cutoff	Payment Penalty?	Est. Annual Impact
0.4600	0.3379	Yes	(\$1,412,800)

## Estimated FFY 2024 Performance

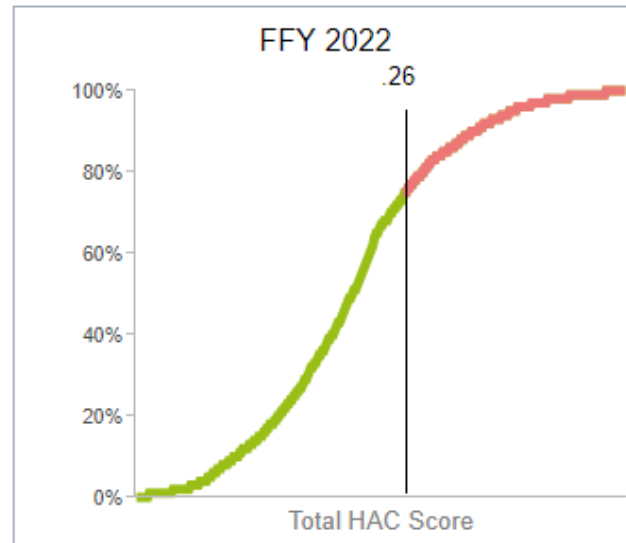
Lower is Better

Measure	Base Score	Measure Z-Score
AHRQ Claims Based		
PSI-90-Safety	0.8100	-1.2604

## CDC Chart Abstracted

HAI-1	1.0770	0.0425
HAI-2	0.5330	-0.4932
SSI	2.0050	2.0812
HAI-5	2.3600	1.7203
HAI-6	0.6800	0.6698

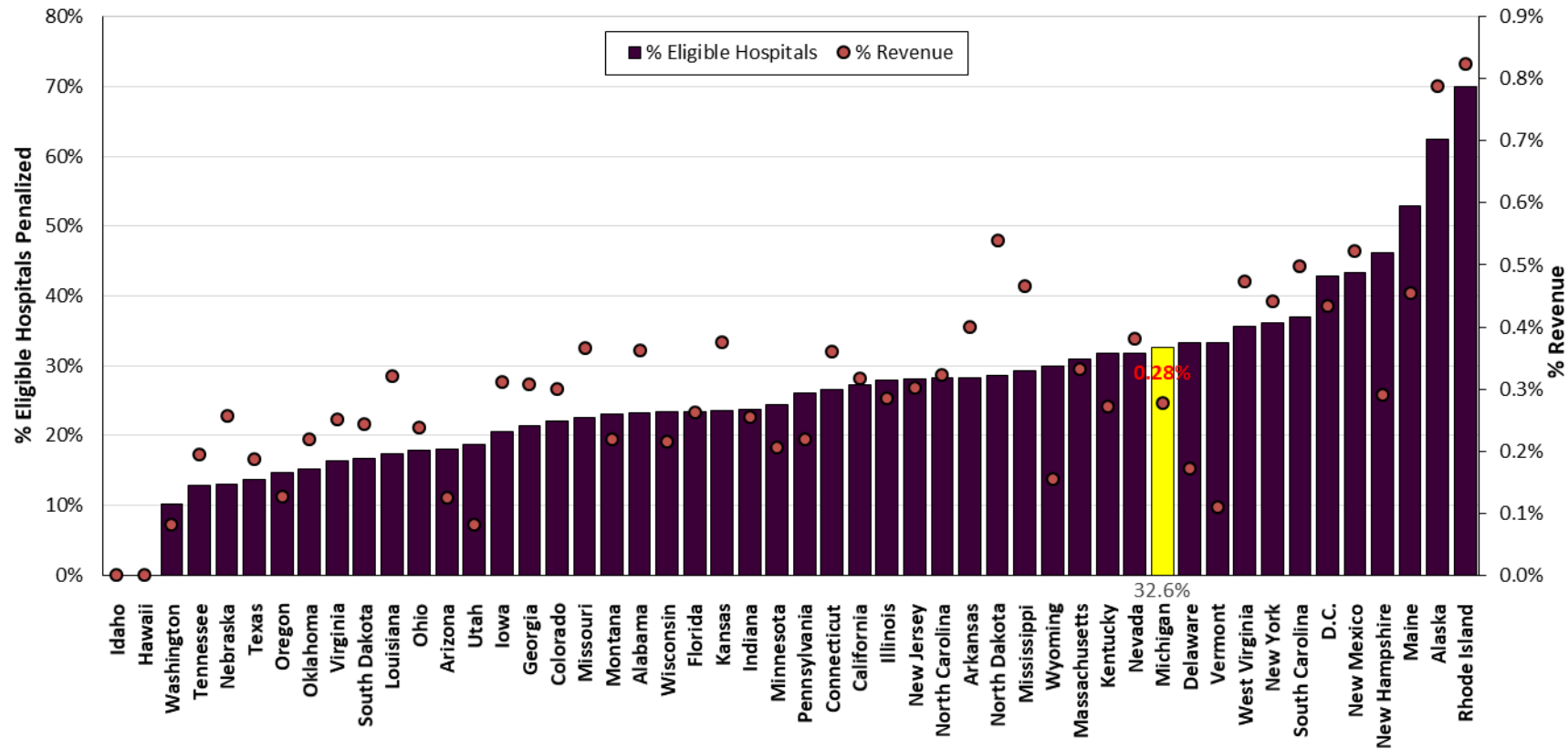
# Hospital Acquired Condition: Hospital Case Study



- Hospital does worse (Total HAC score increases) from 2020 to 2021.
- Hospital goes from penalty in 2020 to no penalty in 2021 (even with better performance in 2020 compared to 2021) because a hospital must keep up with other providers in the US in order to avoid getting a penalty.
- Even if all hospitals improve, 1.0% penalty is always applied to worst performing quartile.

	2020	2021	2022
PSI-90 Score	-0.0183	-0.1267 ▼	1.4252 ▼
HAI-1 CLABSI Score	0.3678	-0.1342 ▼	-1.291 ▼
HAI-2 CAUTI Score	0.8354	0.2816 ▼	1.0445 ▼
SSI Colon/Abd. Score	-1.5000	0.0929 ▲	-0.398 ▼
HAI-5 MRSA Score	N/A	N/A	- N/A ▲
HAI-6 C.Diff Score	1.9710	1.5775 ▼	0.5193 ▼
Total HAC Score	0.3312	0.3382 ▲	0.2599 ▼
75th Percentile Total HAC Score	0.3306	0.3383	0.2998
<b>Receives 1.0% Reduction?</b>	Yes	No	No

# MI's HAC Reduction Program Performance

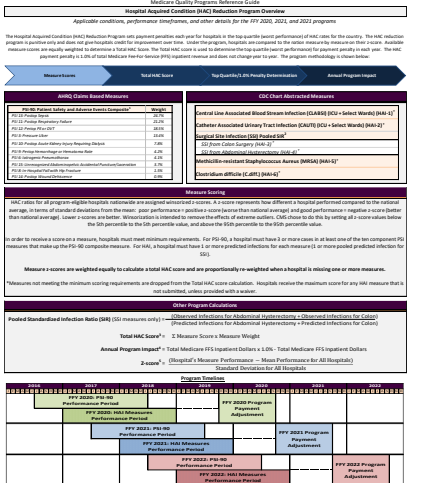
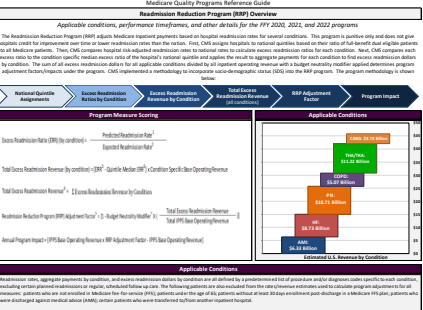


HAC Reduction Program Performance			
	FFY 2020	FFY 2021	FFY 2022
<b>Statewide Impact</b>	(\$11,515,400)	(\$14,326,300)	(\$12,090,900)
<b>Number of Penalty Hospitals</b>	18	24	30
<b>Percent of Hospitals Receiving Penalty</b>	19.6%	26.1%	32.6%
<b>Percent of Total Revenue Affected</b>	0.28%	0.34%	0.28%

Eligible providers and their characteristics are based on the FFY 2023 IPPS Final Rule Correction Notice.

# Quality Program Reference Guide

Value Based Purchasing (VBP) Overview: FFY 2020 Program		
Measure ID	Measure Description	Measure Domain
M01-20-C0101	Central Line Associated Blood Stream Infection (CLABSI) - Select Weeks (M01-20)	Health Care Safety
M01-20-C0102	Central Line Associated Urinary Tract Infection (CAUTI) - Select Weeks (M01-20)	Health Care Safety
M01-20-C0103	Central Line Associated Ventilator-Associated Pneumonia (CLAP) - Select Weeks (M01-20)	Health Care Safety
M01-20-C0104	Unplanned Intensive Care Unit (ICU) Admissions - Select Weeks (M01-20)	Health Care Safety
M01-20-C0105	Unplanned Intensive Care Unit (ICU) Transfers - Select Weeks (M01-20)	Health Care Safety
M01-20-C0106	Unplanned Intensive Care Unit (ICU) Discharges - Select Weeks (M01-20)	Health Care Safety
M01-20-C0107	Unplanned Intensive Care Unit (ICU) Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0108	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0109	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0110	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0111	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0112	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0113	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0114	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety
M01-20-C0115	Unplanned Intensive Care Unit (ICU) Admissions, Transfers, Discharges, and Deaths - Select Weeks (M01-20)	Health Care Safety



**Value Based Purchasing (VBP) Overview: FFY 2020 Program**

**Value Based Purchasing (VBP) Overview: FFY 2021 Program**

**Value Based Purchasing (VBP) Overview: FFY 2022 Program**

**Medicare Quality Programs Reference Guide**

**Regular Scoring Method and Other Program Details for the VBP Program**

As required by the ACA, VBP eligible hospitals contribute a set percentage of their Medicare IPPS base operating payments to a national VBP pool of dollars. All VBP pool dollars are then paid out, in full, based on each hospital's performance under the program. Under the program, hospitals are evaluated on a measure by measure basis and receive a score of 0-100 on each measure where they meet each measure's minimum requirement. Each similar measure is grouped into domains and overall domain scores are calculated based on the average measure scores on the domain. Domain scores are then combined to find a "Total Performance Score" (TPS). The TPS serves as the basis for determining hospitals' VBP payments or gains/losses under the program. Using program-eligible hospitals' Total Performance Scores, CMS calculates a VBP slope that redistributes all VBP contributions and makes the program budget neutral nationally. Each hospital's TPS multiplied by the slope determines payment percentages. The program methodology is shown below.

**Measure Score Calculation**

For each measure, hospitals can receive a score of 0-100 depending on where they fall in relation to national performance standards (achievement points) and/or how much they have improved from historical rates (improvement points). After achievement and improvement points are calculated, the higher of the two determines final points for each measure.

**Achievement Points (all program measures)** = (Final Performance Period Score - Benchmark - Achievement Threshold) x 0.5  
**Improvement Points (all program measures)** = [(Final Performance Period Score - Benchmark) - Benchmark Period Score] x 0.5  
**Final Points (all program measures)** = Higher of Achievement or Improvement

**Final Points (20 Measures)** = Final Points (x) + Predicted Outcomes (y) + Final Points (z) + Predicted Outcomes (w)

**Person and Community Engagement - Consistency Points Calculation**

In addition to individual measure scores, the Person and Community Engagement domain scores hospitals based on how consistently they perform across all measures within the domain. Each hospital can receive between 0-20 consistency points based on the measure with the lowest consistency multiplier calculated as shown below.

**Consistency Points (person and community engagement)** = [(20 - Lowest Measure Consistency Points Multiplier) x 0.5]

**Consistency Points Multiplier (person and community engagement)** = Floor (Achievement Threshold - Floor)

**Domain Score and Total Performance Score Calculation**

Individual measure scores for similar measures are combined to find overall domain scores. On each domain, a minimum number of measures must be scored in order to be eligible for the domain. Once domain scores are calculated, a performance score is calculated, combining domain scores based on the program year's applicable domain weights. Hospitals are required to score on 3 of the 4 domains. Domain weights are reweighted proportionally when hospitals are not eligible for one or more domains.

**Overall Domain Score** =  $\frac{\text{Score of the Top Performer on Each Domain}}{\text{Domain Points Factor on Each Domain}}$

**Proportionally Reweighted Domain Weight (PPS 2015-1)** =  $\frac{\text{Domain Points Factor on Each Domain}}{\text{Sum of Domain Points Factors on All Scored Domains}}$

**Total Performance Score (TPS)** = (Domain 1 score x Domain 1 Weight + Domain 2 score x Domain 2 Weight + Domain 3 score x Domain 3 Weight)

**VBP Adjustment Factors, Payment Percentages, Adjustment Factors and Program Impact Calculation**

Once TPS scores are calculated for all eligible hospitals, the VBP slope is calculated such that all program contributors are paid out, making the program budget neutral nationally. The VBP slope/linear function is used to determine each hospital's payment percentage (the amount of their contribution to the VBP pool they receive back), as well as final adjustment factors, and impacts under the program.

**VBP Lower Function (Payment Percentage)** = (Total Performance Score x VBP Slope)

**VBP Adjustment Factor** = (1 - Program Contribution Percentage x Fixed Percentage) + Program Contribution Percentage

**Adjusted Program Impact** = (PPS Base Operating Budget - VBP Adjustment Factor x PPS Base Operating Budget)

**Medicare Quality Programs Reference Guide**  
**Reimbursement Reduction Program (RRP) Overview**

Applicable conditions, performance thresholds, and other details for the FFY 2020, 2021, and 2022 programs

The Reimbursement Reduction Program (RRP) allows Medicare payment providers based on hospital performance for various conditions. The program provides rate and does not guarantee that the payment rates for their performance over their years. The CMS will compare the hospital's performance to the national average performance for each condition. If a hospital's performance is below the national average performance, the hospital's payment rates will be reduced. The CMS will calculate the hospital's adjusted payment rates for each condition. The CMS will compare each hospital's adjusted payment rates to the national average performance for each condition. The CMS will reduce the payment rates for each condition to the national average performance for that condition. The sum of all reduced payment rates for all applicable conditions will be used to reduce the hospital's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year.

**Applicable Conditions**

The diagram shows the applicable conditions for the RRP program, including various medical conditions and procedures.

**Applicable Conditions**

**Program Impact**

The diagram shows the program impact, including the impact on Medicare payment rates and the impact on the hospital's performance.

**Program Impact**

**Program Impact**

**Program Impact**

**Medicare Quality Programs Reference Guide**  
**Hospital Quality Program Reference Guide**

Applicable conditions, performance thresholds, and other details for the FFY 2020, 2021, and 2022 programs

The Hospital Quality Program (HQP) allows Medicare payment providers based on hospital performance for various conditions. The program provides rate and does not guarantee that the payment rates for their performance over their years. The CMS will compare the hospital's performance to the national average performance for each condition. If a hospital's performance is below the national average performance, the hospital's payment rates will be reduced. The CMS will calculate the hospital's adjusted payment rates for each condition. The CMS will compare each hospital's adjusted payment rates to the national average performance for each condition. The CMS will reduce the payment rates for each condition to the national average performance for that condition. The sum of all reduced payment rates for all applicable conditions will be used to reduce the hospital's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year. The CMS will reduce the hospital's Medicare payment rates for that year by the amount of the CMS's Medicare payment rates for that year.

**Measure Scoring**

The diagram shows the measure scoring process, including the calculation of measure scores and the impact of the scores on the hospital's performance.

**Measure Scoring**

**Measure Scoring**

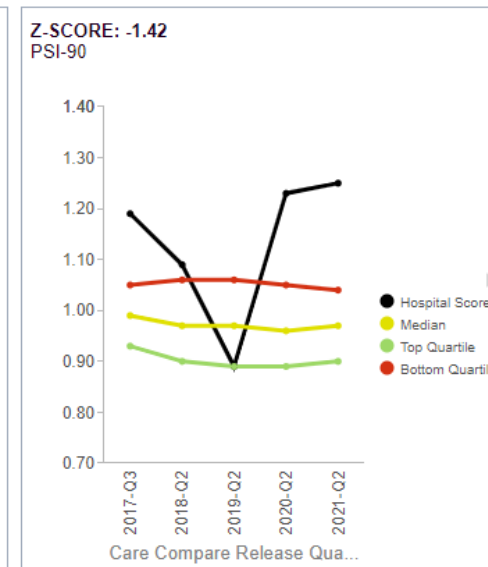
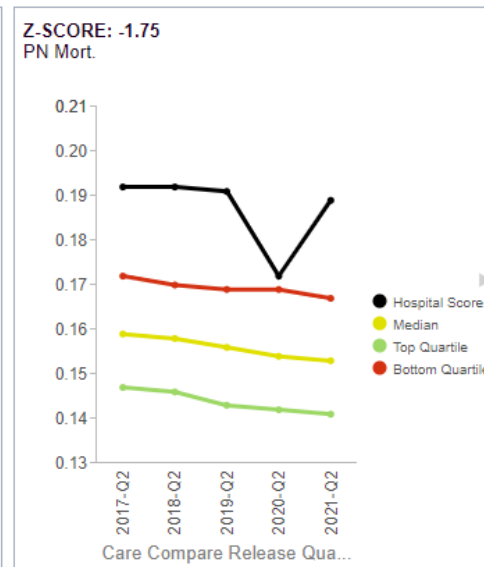
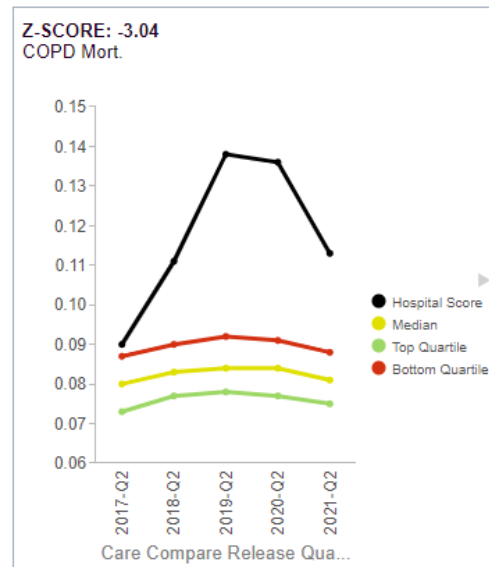
**Measure Scoring**

**Measure Scoring**

# Quality Program Measure Trends

- Chasing a moving target

- Measures/Domains
- National Improvement Trends
- Performance Standards
- Z-scores



# Hospital-Specific One-Pager Report



- 3-year trend for each hospital
- FFYs 2021-2023
- Actual performance on all 3 programs: VBP, RRP, HAC



# Other Quality Data Sources

- Care Compare
- Quality Net
- Other

# Key Reminders for Hospitals

- Payments are at stake
- Historical data will continue to drive these programs
- Program targets move with national performance, so hospitals must keep pace with the pack
- Complexity of program measures
- Overlap with other quality based payment reform programs
  - VBP & HAC: CAUTI, CLABSI, Surgical Site Infection (SSI), MRSA and C-Diff Measures
  - VBP & RRP: THA/TKA, AMI, HF, PN, CABG, and COPD
- **HACs will have a worst performing 25%**

# Thank you.



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