Hospital Quality Incentive Program
State Fiscal Year (SFY) 2016-2017
Q&As

Q1: How will this Hospital Quality Incentive Program be coordinated with the Department of Human Services' (DHS) other Value-Based Purchasing (VBP) initiatives?

A: DHS is moving towards a value based purchasing strategy that will encourage hospitals and health systems to move towards becoming accountable care organizations. By 2019 DHS will require Managed Care Organizations (MCOs) to include 30% of their premium to pay providers using an alternative payment method. This is aligned with the Centers for Medicare and Medicaid Services' (CMS) goals within the Medicare program.

Hospitals and health systems work within their communities via the community needs assessment to define ways to work with their primary care providers and specialists to better coordinate and manage the care of those with ambulatory sensitive conditions. Hospitals and health systems also work closely with DHS's Medical Assistance (MA) MCOs to better coordinate care. DHS intends to contractually require MA MCOs to share detailed claims information with hospitals and health systems as part of value-based payment arrangements.

Preventable admissions for four conditions - Diabetes, Asthma, COPD, and CHF - are Medicaid Adult Core measures established by CMS and have been measured by DHS's MCOs for the past 3 years. DHS has held MCOs accountable for preventable admissions for the past 10 years.

Q2: Is this Hospital Quality Incentive Program necessary under the Centers for Medicare and Medicaid Services (CMS) Regulations?

A: This Hospital Quality Incentive Program is designed to incentivize acute care general hospitals enrolled in the Pennsylvania MA Program's Physical Health HealthChoices Program to improve the quality of healthcare services they provide. DHS developed this initiative as part of its commitment to promote cost-effective, quality healthcare through an outcome and value-based payment structure and believes it to be consistent with CMS regulations.

Q3: Why did DHS choose 3M's Population-focused Preventable Software?

A: This risk-adjusted software is already being used by several of DHS's MA MCOs as a health system strategy evaluating preventable events.

Q4: Is this software used in other states?

A: Yes. According to 3M, payors in 20+ states (including government and commercial payors) use inpatient components of their software.

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Q5: What is a preventable admission? Is "preventable admissions" a tested measure, or is implementation of this approach counter to state and federal efforts to streamline existing quality metrics?

A: A potentially preventable admission (PPA) as related to this Hospital Quality Incentive Program is generally aligned with the Agency for Healthcare Research and Quality's (AHRQ) Prevention Quality Indicators (PQI), which focus on ambulatory care sensitive preventable events. (See http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)

"The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."

"Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management."

The following is the list of AHRQ's ambulatory sensitive preventable admissions:

Bacterial Pneumonia Admission Rate
Dehydration Admission Rate
Pediatric Gastroenteritis Admission Rate - **PPA adds adults**
Urinary Tract Infection Admission Rate
Perforated Appendix Admission Rate- **not part of PPA**
Low Birth Weight Rate- **not part of PPA**
Angina without Procedure Admission Rate
Congestive Heart Failure Admission Rate
Hypertension Admission Rate
Adult Asthma Admission Rate
Pediatric Asthma Admission Rate
Chronic Obstructive Pulmonary Disease Admission Rate
Uncontrolled Diabetes Admission Rate
Diabetes Short-Term Complications Admission Rate
Diabetes Long-Term Complications Admission Rate- **not part of PPA**
Rate of Lower-Extremity Amputation among Patients with Diabetes- **not part of PPA**

3M's PPAs exclude four conditions noted above but add Seizures, Migraines, Chest Pain, Cardiac Catheterization, Abdominal Pain, Back Procedures (disc pain), and Sickle Cell Anemia.

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Below is an example of the 3M list of preventable admissions listed by APR-DRG, clinical condition, and percent of preventable events within the Pennsylvania Medicaid HealthChoices program.

APR-DRG	Condition	Percent
0141	ASTHMA	11.0%
0140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	9.9%
0139	OTHER PNEUMONIA	7.7%
0137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	1.4%
0194	HEART FAILURE	5.2%
0203	CHEST PAIN	4.0%
0198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	1.8%
0191	CARDIAC CATHETERIZATION W CIRC DISORD EXC ISCHEMIC HEART DISEASE	1.5%
0199	HYPERTENSION	1.1%
0383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	9.6%
0420	DIABETES	8.2%
0422	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	1.2%
0053	SEIZURE	7.5%
0054	MIGRAINE & OTHER HEADACHES	1.7%
0249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	4.1%
0251	ABDOMINAL PAIN	2.3%
0245	INFLAMMATORY BOWEL DISEASE	1.6%
0463	KIDNEY & URINARY TRACT INFECTIONS	4.3%
0662	SICKLE CELL ANEMIA CRISIS	5.2%
0113	INFECTIONS OF UPPER RESPIRATORY TRACT	2.7%
		92.0%

Exclusions:
The following conditions are excluded from the analysis - metastatic malignancies, serious multiple trauma, extensive burns, Catastrophic conditions include long term dependency on a medical technology (e.g., dialysis, respirator, TPN) and life-defining chronic diseases or conditions that dominate the medical care (e.g., persistent vegetative state, cystic fibrosis, history of heart or liver transplant).

Risk adjustment:
APR-DRGs categorize each stay into 4 levels of severity; all claims are pulled on individuals with a preventable event to assign an overall clinical risk score.

3M's system is designed with consultation of several clinical groups - adult and geriatric expert panels and the National Association of Children's Hospitals and Related Institutions (NACHRI). The later focused on pediatric and Medicaid specific issues.

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This approach is not counter to state and federal efforts to streamline existing quality metrics. Preventable admissions for four conditions Diabetes, Asthma, COPD, and CHF are Medicaid Adult Core measures established by CMS and have been measured by our MCOs for the past 3 years. DHS has held MCOs accountable for preventable admissions for the past 10 years.

Q6: How will events be counted? For example, if a single patient admission results in multiple "events," would the total of those events be counted in the denominator? And, subsequently, if multiple events were deemed "preventable," would they all be counted in the numerator?

A: Events in the denominator and numerator will be acute inpatient stays paid by the Physical Health MCOs. They will not include acute rehabilitation stays or observation stays. They will not include events for dual-eligible individuals over 21 years of age. An event will be defined from the date of admission to the date of discharge. A single admission will be counted only once.

Q7: How do admission authorizations from MA MCOs effect the methodology – i.e. the hospital contacts the MCO, the patient meets criteria, and the admission is approved? Does the Hospital Quality Incentive Program consider admissions such as these as a preventable event candidate?

A: Only paid admissions are considered for the Hospital Quality Incentive Program. Denied claims and observation status (which is considered an outpatient service) will not be included. Any admission with a primary diagnosis that falls into the list of conditions above is considered potentially preventable. The 3M software excludes most planned or staged surgical events or planned medical readmissions.

Q8: Did DHS consider incorporating measures similar to the current Medicare VBP program into the design of this Hospital Quality Incentive Program?

A: DHS considers this program to be congruent with Medicare's value based strategy of moving towards an accountable care organization delivery system and alternative payment methods that reward for access and quality of care across the entire continuum. Medicare's VBP program requires intensive data collection across four domains which is not currently available for the Medicaid population. Medicare's program focuses primarily on reducing hospital payment which is counter to DHS's objective of developing a positive incentive program.

Q9: Is the dual-eligible population included?

A: The Hospital Quality Incentive Program does not include events for dual-eligible individuals over 21 years of age. This program focuses on inpatient services within the Pennsylvania Medicaid Physical Health managed care delivery system.

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Q10: Why does the Hospital Quality Incentive Program have two measures, incremental improvement and benchmark?

A: DHS (in consultation with HAP) believes both incremental improvement and benchmarks measures are helpful in rewarding hospitals that already have a lower rate of preventable events in addition to hospitals that improve year after year.

Q11: Why doesn't the methodology include a "high performers" measure, in which performers attaining a very high percentile, such as the 90th percentile, are awarded both incentives (incremental and benchmark)?

A: The benchmark component of the Hospital Quality Incentive Program has two levels of reward – the 25th and 50th percentile. Hospitals that qualify for both the incremental improvement and benchmark measure are rewarded for both measures.

Q12: How does this quality program address avoidable admissions? How can hospitals be held accountable for care delivery failures that may occur in the primary care setting outside the control of individual hospitals? How can a hospital be expected to influence care/change patient behaviors to prevent admissions when some MA MCOs do not assign patients to a primary care provider?

A: As noted above, DHS is adopting a value based purchasing strategy that will encourage hospitals and health systems to move towards becoming accountable care organizations.

Currently, however, all HealthChoices members are assigned a primary care provider. Hospitals and health systems should be working within their communities via the community needs assessment to define ways to work with their patients' primary care providers and specialists to better coordinate and manage the care of those with ambulatory sensitive conditions. Hospitals and health systems should also be working closely with HealthChoices MCOs to better coordinate care.

Q13: How does the Hospital Quality Incentive Program address socio-economic status? How does it adjust for risk?

A: This hospital quality initiative will measure hospital performance based solely on Medicaid managed care events. Each of the measures (incremental improvement and benchmark) will compare the performance of Medicaid events to Medicaid events thus limiting socio-economic factors to those found in the Medicaid population and not across other populations. Hospitals/Health Systems are measured on their own populations within their communities for the incremental payments.

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DHS has requested 3M to provide additional information to further explain the risk adjustment within their software. While socioeconomic determinates of health (SED) are an interesting set of variables, the National Quality Forum (NQF) has evaluated several resource utilization quality metrics with and without SED variables and found no significant contribution of SED on the results. SED does not necessarily contribute to variation in quality or resource utilization.

Q14: How will the Hospital Quality Incentive Program payments be distributed? How will the hospital quality payment be paid through the MCOs? What assurances do hospitals have that MCOs will pay the hospitals the full $25 million for SFY 2016-17? If the Hospital Quality Incentive Program's payments are calculated in aggregate of all qualifying MA managed care claims with payments made through an MCO remittance, how will DHS determine which MA MCO will process the payment?

A: MCOs will be contractually required to pay out the entire $25 million for the SFY 2016-17 Hospital Quality Incentive Program. Beginning in July 2017 to allow for claim runout, DHS will review all inpatient encounter data for CY 2016 dates of service submitted to DHS by the Physical Health MCOs. DHS will run the encounter data through the 3M Population-focused Preventable Software to determine eligibility for the program and calculate payment amounts for each qualifying hospital. By September 2017, DHS will communicate hospital-specific payment amounts to the MCOs. Qualifying hospitals can expect to receive payment from the MCO in September 2017. DHS will review the MCO quality incentive payments to ensure the entire $25 million was paid to hospitals. DHS is in the process of determining how to allocate payments among MA MCOs.

Q15: Is the MCO contract language available that requires the MCOs to pay all of the $25 million out to hospitals?

A: The language is currently being finalized.

Q16: Why is this initiative being funded by the revenue generated by the Statewide Quality Care Assessment Program? Is the Statewide Quality Care Assessment Program funded with inpatient or outpatient funds? Is the $25 million available for the SFY 2016-17 Hospital Quality Incentive Program total funds or state only? Does this Hospital Quality Incentive Program require CMS approval? What happens to the $25 million allocated for the SFY 2016-17 program if CMS approval is not obtained?

A: The Assessment Program is a Statewide Quality Care Assessment Program. This Hospital Quality Incentive Program, which is focused on inpatient acute care general hospitals, builds upon DHS' shift to Value-Based Purchasing. A total of $25 million of combined state and federal funding will be available for the SFY 2016-17 Hospital Quality Incentive Program through the MCO agreements. DHS believes the Hospital

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Quality Incentive Program is consistent with CMS's recently released final regulations. In the event that CMS requires changes to the program, DHS will work with CMS and share any such changes with the hospital community.

Q17: Does this Hospital Quality Incentive Program count in the hospital-specific Disproportionate Share Hospital (DSH) Upper Payment Limit (UPL) analysis?

A: DHS's reading of CMS' final Medicaid managed care regulations published on May 6, 2016 is that quality payments, such as the Hospital Quality Incentive Program, do not count toward hospital-specific DSH UPL analysis. DHS intends to seek further guidance on this topic from CMS.

Q18: Since September 2017 is the target date for payment to hospitals, does that mean SFY 2016-17 has $25 million remaining?

A: As with certain other hospital payments, Hospital Quality Incentive Program payments will be made on an accrual basis, in that the $25 million although being expended in SFY 2017-18 will be counted against the SFY 2016-17 funding amount.

Q19: Why was hospital community feedback due by July 20, 2016?

A: DHS is committed to beginning this Hospital Quality Incentive Program as soon as possible to build upon existing quality programs and will consider all comments received by July 20, 2016. In developing the Program DHS sought and incorporated input from the Hospital & Healthsystem Association of Pennsylvania (HAP).

Q20: How can hospitals be expected to materially affect performance in CY 2016 given this initiative is just now being announced? Did DHS consider CY 2015 as the baseline with CY 2017 as the performance period? When will the CY 2015 benchmarks be announced? Did DHS give consideration to implement the initial year of the Hospital Quality Incentive Program as a pilot program?

A: This measure of preventable events was chosen, in part, because it is aligned with other quality incentive programs, including Medicare. Hospitals should have programs already in place within their communities to reduce preventable events. Hospitals should be working with their PCPs and specialists to assure timely access to high quality of care. Using CY 2016 as the first performance period allows DHS to begin this hospital quality initiative without delay. DHS expects to release the CY 2015 preventable event percentage statistics representing the 25th and 50th percentile for the benchmark measure in September 2016.

Q21: How will the model deal with situations where specific claims denials were overturned following internal provider appeals?

A: For most hospitals, the number of claims under appeal are not a significant portion of the hospital's MA managed care claim volume. Also, DHS' agreements with MCO's requires that provider appeal resolutions be complete within a specific timeframe; therefore, six month claim runout from the last service day of the performance period will allow sufficient time for the analysis to consider most appeal situations that are submitted to DHS.

Q22: Will DHS provide hospitals with claim detail so that hospitals can identify and improve upon those identified events?

A: DHS will provide each hospital with the number of preventable events that occurred within each of the 25 APR-DRGs. DHS will also provide 2015 benchmark data by September 2016.

Q23: The MA MCOs frequently downgrade patients' stays to observation or only initially approve them as observation instead of inpatient. How will observation cases be classified or counted with the 3M software? Will observation cases be included? What are the implications for observation cases downgraded after review?

A: Observation services are not included in this Hospital Quality Incentive Program which is focused on inpatient services.

Q24: Are inpatient rehabilitation hospitals included in this Hospital Quality Incentive Program?

A: The SFY 2016-17 Hospital Quality Incentive Program is a program solely for inpatient acute care general hospitals. As DHS expands its outcome and value-based payment structure, quality incentive programs may be rolled out to other provider types.

Q25: What are the cost report effects related to these funds (Medicare and Medicaid)? Will hospitals be required to offset these funds on the cost reports? Will these funds need to be reported on S-6 or S-7 of the MA-336? What about S-10 of the Medicare Cost Report?

A: For Medicaid hospital cost reporting purposes, all payments received by hospitals which are funded by the Statewide Quality Care Assessment must be included on the Medicaid Hospital Cost Report (Schedule A3) as offset against the assessment payment made by the hospital to the extent of the hospital's assessment cost. The entire payment must be included as revenue within Schedule S6 of the Medicaid Hospital Cost Report. Hospitals should refer to Medicare Cost Report instructions to determine whether/where the Hospital Quality Incentive Payment is to be included on the Medicare Cost Report.

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Q26: When will hospitals be informed about the SFY 2017-18 Hospital Quality Incentive Program? Will hospitals be involved in the development of the SFY 2017-18 Hospital Quality Incentive Program? Will funding for the SFY 2017-18 Hospital Quality Incentive Program increase from $25 million?

A: At the present time, DHS is focused on implementing the Hospital Quality Incentive Program for SFY 2016-2017. As DHS moves forward with this Program in future years, DHS will continue to seek input from HAP and the hospital industry.