

Hospital Quality Incentive (HQI) Program  
State Fiscal Year (SFY) 2017-2018  
Q&As

**Q1: How will this HQI 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 thirty percent (30%) of their premium to pay providers using an alternative payment method. This program 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' Medical Assistance (MA) MCO's to better coordinate care. DHS intends to contractually require MA MCO's to share detailed claims information with hospitals and health systems as part of value-based payment arrangements.

Preventable admissions for four conditions - Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF) - are Medicaid Adult Core measures established by CMS and have been measured by DHS' MCOs for the past several years. DHS has historically held MCOs accountable for preventable admissions.

**Q2: Is this HQI Program necessary under the CMS regulations?**

A: This HQI Program is designed to incentivize acute care general hospitals enrolled in the Pennsylvania (PA) 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' MA MCOs as a health system strategy evaluating preventable events.

**Q4: Is this software used in other states?**

A: Yes. According to 3M, at the time of program development, payors in more than twenty (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 HQI 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](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**

As part of the HQI Program’s continuing development, 3M’s PPAs exclude four conditions noted above but add Seizures, Migraines, Chest Pain, Cardiac Catheterization, Abdominal Pain, and Back Procedures (disc pain).

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Below is an example of the 3M list of preventable admissions listed by All Patients Refined Diagnosis Related Groups (APR-DRG), clinical condition, and percent of preventable events within the PA MA HealthChoices program.

<b>APR-DRG</b>	<b>Condition</b>	<b>Percent</b>
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%
0463	KIDNEY & URINARY TRACT INFECTIONS	4.3%
0113	INFECTIONS OF UPPER RESPIRATORY TRACT	2.7%
		85.2%

**Exclusions:**

The following conditions are excluded from the analysis: metastatic malignancies, serious multiple trauma, extensive burns, sickle-cell anemia crisis, catastrophic conditions including 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 four (4) levels of severity. All claims are pulled on patients with a preventable event to assign an overall clinical risk score.

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

This approach is not counter to state and federal efforts to streamline existing quality metrics. Preventable admissions for four (4) conditions (Diabetes, Asthma, COPD, and

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CHF) are Medicaid Adult Core measures established by CMS and have been measured by MA MCOs for the past several years. Historically, DHS has held MA MCOs accountable for preventable admissions.

**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 numerator and denominator will be acute inpatient stays paid by the Physical Health MCOs. Events will not include acute rehabilitation stays, observation stays, or dually eligible individuals over twenty-one (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 HQI Program consider these admissions as preventable event candidates?**

A: Only paid admissions are considered for the HQI 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 HQI 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 (4) domains which is not currently available for the Medicaid population. Medicare’s program focuses primarily on reducing hospital payment which is counter to DHS’ objective of developing a positive incentive program.

**Q9: Is the dually eligible population included?**

A: The HQI Program does not include events for dually eligible individuals over twenty-one (21) years of age. This program focuses on inpatient services within the PA MA Physical Health managed care delivery system.

**Q10: Why does the HQI Program have two measures (incremental improvement and benchmark)?**

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A: DHS, in consultation with the Hospital and Healthsystem Association of Pennsylvania (HAP), believes both incremental improvement and benchmark measures are helpful for 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 ninetieth (90<sup>th</sup>) percentile, are awarded both incentives (incremental and benchmark)?**

A: the benchmark component of the HQI Program for Non-Children's hospitals continues with two levels of reward – the twenty-fifth (25<sup>th</sup>) and fiftieth (50<sup>th</sup>) percentile. Hospitals that qualify for both the incremental improvement and benchmark measure are rewarded for both measures. Beginning with the State Fiscal Year (SFY) 2017-2018 (Calendar Year [CY] 2017 performance period), Children's Hospitals have one level of reward – the fiftieth (50<sup>th</sup>) percentile.

**Q12: How are Children's Hospitals treated within the HQI program?**

A: Beginning with the SFY 2017- 2018 (CY 2017 performance period), Children's Hospitals will be evaluated under a separate benchmark measure. The Children's Hospital Benchmark will be calculated as the prior year's median preventable event statistic among Children's Hospitals. Calculation of this median excludes low volume Children's Hospitals.

**Q13: How does the HQI 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 and/or 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 (CNA) 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.

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**Q14: How does the HQI Program address socioeconomic status? How does it adjust for risk?**

A: The HQI Program 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 and health systems are measured on their own populations within their communities for the incremental payments.

While Socio-Economic Determinants 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.

**Q15: How will the HQI 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 program funding amount? If the HQI 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 funding amount for each fiscal year of the HQI Program. Using the second program year as an example, beginning in July 2018 to allow for claim runout, DHS will review all inpatient encounter data for CY 2017 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 October 2018, DHS will communicate hospital-specific payment amounts to the MCOs. Qualifying hospitals can expect to receive payment from the MCO by the end of October 2018. DHS will review the MCO quality incentive payments to ensure the entire funding amount for the program year was paid to hospitals. MCOs will share payments to their network hospitals in their zones of operation.

**Q16: If a hospital pays the Statewide Quality Care Assessment, but does not contract with an MA MCO, is that hospital eligible to receive an HQI payment?**

A: A hospital that does not contract with an MA MCO would have zero MCO encounters, and therefore qualify for \$0 payment.

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**Q17: Is the MCO contract language available that requires the MCOs to pay all of the program funding out to hospitals?**

A: The SFY 2017-2018 HQI payment language is currently being finalized by DHS for inclusion in the CY 2018 Physical Health HealthChoices agreements.

**Q18: 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 full program funding amount available for each SFY of the HQI Program total funds or state only? Does this HQI Program require CMS approval? What happens to the full program funding amount allocated for each SFY if CMS approval is not obtained?**

A: The Assessment Program is a Statewide Quality Care Assessment Program. The HQI Program, which is focused on inpatient acute care general hospitals, builds upon DHS' shift to VBP. The full program funding amount, comprised of state and federal funding, will be available for each SFY of the HQI Program through the MCO agreements. DHS believes the HQI Program is consistent with CMS' 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.

**Q19: Does this HQI Program count in the hospital-specific Disproportionate Share Hospital (DSH) Upper Payment Limit (UPL) analysis?**

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

**Q20: Since October is the target for payment to hospitals, does that mean each SFY has the full program funding amount remaining?**

A: As with certain other hospital payments, HQI Program payments will be made on an accrual basis, once the proper CY data is available.

**Q21: Why is this payment for the CY 2017 performance period, targeted to be paid to hospitals in October 2018, counted against SFY 2017-2018 funds?**

A: This is due to the need for encounter data runout, which is not available until early August of the subsequent CY.

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**Q22: When will the benchmarks for the SFY 2017-2018 program (CY 2017 performance period) be available?**

A: DHS will release the CY 2016 preventable event percentage statistics for the benchmark measures on the DHS website at <http://www.dhs.pa.gov/provider/hospitalassessmentinitiative/>. DHS will measure each hospital's CY 2017 performance against these CY 2016 baseline benchmark statistics. Hospitals will receive their hospital-specific CY 2017 performance data as part of the SFY 2017-2018 payment correspondence. DHS will notify hospitals when the benchmark measures are available for review.

**Q23: How will the model deal with situations where specific claim 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 MCOs requires that provider appeal resolutions be complete within a specific timeframe. Therefore, a six (6) 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.

**Q24: Will DHS provide hospitals with claim detail so that hospitals can identify and improve upon those identified events?**

A: DHS intends to provide hospital-specific totals for preventable events in each of the twenty-two (22) APR-DRGs as part of the annual payment notification. DHS will not provide specific claims detail.

**Q25: 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 HQI Program which is focused on inpatient services.

**Q26: Are inpatient rehabilitation hospitals included in this HQI Program?**

A: At this time, the HQI 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.

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**Q27: 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 A-3) 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 S-6 of the Medicaid Hospital Cost Report. Hospitals should refer to Medicare Cost Report instructions to determine whether/where the HQI Program should be included on the Medicare Cost Report.