AMERICAN PSYCHIATRIC ASSOCIATION

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Overview of Current Quality Programs

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A general overview of current federal or national quality performance and reporting programs for health care, designed to introduce APA members and their staffs to these programs. For further information, please contact Samantha Shugarman, M.S., APA Deputy Director of Quality, as sshugarman@psych.org, or 202-559-3606.

MEDICARE PHYSICIAN / CLINICIAN REPORTING

Quality Reporting Program (QPP): This is the ONLY program that requires direct reporting by individual physicians and clinicians and/or group practices that include them. The QPP includes both the Merit-based Incentive Payment System (MIPS) AND quality reporting for "Advanced" Alternative Payment Models. Results are reported on the Physician Compare public website.

- QPP currently applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists. "Physicians" include podiatrists, optometrists, chiropractors, oral surgeons, and dentists.
- Likely to be added beginning w/2019 performance year: Other Medicare "non-physician practitioners" --clinical social workers, clinical psychologists, physical therapists, occupational therapists, audiologists, speech-language therapists, registered dieticians, and nurse midwives.

MEDICARE FACILITY-BASED REPORTING

These programs require quality reporting by the appropriate facility or agency. Those that seem most relevant to psychiatry are listed first.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: These requirements apply to all IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS). The IPF PPS applies to inpatient psychiatric services given by psychiatric hospitals or psychiatric/mental health/behavioral health units in Acute Care Hospitals (ACHs) or Critical Access Hospitals (CAHs) in the U.S. that participate in Medicare. There is a two-percent reduction in the annual payment update for failing to successfully report.

Hospital Inpatient Quality Reporting Program: CMS collects quality data from hospitals paid under the Inpatient Prospective Payment System (IPPS). There is a two-percent reduction in the annual payment update for failing to successfully report. Results are reported on the Hospital Compare website.

Hospital Value-Based Purchasing (VBP): This program is funded by reducing participating hospitals' base FY 2018 operating Medicare severity diagnosis-related group (MS-DRG) payments by two percent. Any leftover funds are redistributed to hospitals based on their Total Performance Scores (TPS), and how that falls in the range of all hospitals' TPS scores for that year. A hospital can receive a value-based incentive payment that is less than, equal to, or more than the two-percent reduction.

Hospital Outpatient Quality Reporting (OQR) Program: Hospitals receive a two-percent reduction in their annual payment update under the Outpatient Prospective Payment System (OPPS) if they fail to successfully report under this program. Results are reported on the Hospital Compare website.

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP): Beginning in FY 2018, SNFs failing to submit required measures will have their payment rates reduced by two percent. The three assessment-based quality measures are: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay); Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function; and Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay). The three claims-based quality measures are: Total Estimated Medicare Spending Per Beneficiary; Discharge to Community-Post Acute Care– SNF QRP; and Potentially Preventable 30-Day Post Discharge Readmission.

Nursing Home Quality Initiative (NHQI): This website provides consumer and provider information regarding the quality of care in nursing homes and discusses quality measures shown at the Nursing Home Compare website.

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP): LTCHs (sometimes called long-term acute care hospitals, or LTACHs) treat patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. There is a two-percent reduction in the annual payment update for failing to successfully report.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program: ASCs report quality of care data for standardized measures to receive the full annual update to their ASC annual payment rate.

Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP): Results are reported on the IRF Compare website. There is a two-percent reduction in the annual payment update for failing to successfully report.

Home Health Quality Initiative: Medicare Part A covers part-time, medically necessary skilled home health care (RN services plus physical, occupational, and speech-language therapy) ordered by a physician. Medicare-certified home health agencies must report Outcome and Assessment Information Set (OASIS) data for adult patients receiving care (other than just pre/post-natal care) reimbursed by Medicare and Medicaid. Results appear on the Home Health Compare website.

Hospice Quality Reporting Program (HQRP): Hospices must submit quality data through the Hospice Item Set (HIS) collection tool, plus the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®). Otherwise, they receive a two-percent reduction to their annual "market basket percentage increase."

MEDICARE ADVANTAGE

Private payers/insurers contract with Medicare to provide Part A and B benefits to the 1/3 of beneficiaries who sign up for Medicare Advantage (MA) plans. MA plans include HMOs, preferred-provider organizations, private fee-for-service plans, special needs plans, and medical savings account plans. Most plans also offer prescription drug coverage. All MA plans are required to have a quality Improvement (QI) program, which includes reporting HEDIS and CAHPS data, and submit a QI program plan (QIPP). Bonuses are tied to performance on star quality ratings (1-5 stars), which include measures of patient experience.

MEDICAID

CMS partners with states to share best practices and provide technical assistance to improve the quality of care for patients receiving Medicaid and CHIP (Children's Health Insurance Program) benefits. There is no Medicaid quality reporting program at the federal level. Some states have mandatory quality reporting at the state level, but others do not. States also vary in how they administer Medicaid programs and the services they cover.

The Affordable Care Act required the development of a core set of adult health care quality measures in Medicaid for voluntary use by states, managed care organizations, and providers. CMS and the Agency for Health Care Research and Quality (AHRQ) developed a core set of adult quality measures in 2011, and voluntary reporting of these measures began in 2014. CMS has also developed a core set of children's health quality measures in Medicaid and CHIP. CMS is required to report to Congress every three years on the status of voluntary reporting on the core quality measures and other efforts to advance quality of care in Medicaid and CHIP.

The Medicaid Core Measure Set includes measures aligned with federal and accreditation programs. This includes a Behavioral Health Core Set, and Behavioral Health Clinics Quality Measures. CMS has also developed Medicaid Quality Improvement Initiatives for children, adults, maternal and infant health, oral health, prevention, long-term services, and patient safety. Several of these address the issue of tobacco cessation. The prevention initiative supports "clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease." It provides information regarding antipsychotic drug use in children, and developmental and behavioral screening of young children.

JOINT COMMISSION AND OTHER ACCREDITATION ORGANIZATIONS

The various agencies that perform accreditation and establish standards for healthcare delivery include the Joint Commission (TJC), National Committee for Quality Assurance (NCQA), American Medical Accreditation Program (AMAP), Utilization Review Accreditation Commission (URAC), and the Accreditation Association Ambulatory HealthCare (AAAHC). Each develops their own accreditation process, programs, and standards. (Viswanathan HN, et al. Accrediting Organizations and Quality Improvement. *Am J Manag Care*. Oct. 1, 2000.) Psychiatrists representing the APA participate in TJC and URAC.

A facility or practice can always choose not to report the recommended or required measures, but this will affect the score they receive from their accreditation review/onsite survey.

The Specifications Manual for Joint Commission National Quality Measures includes Hospital Based Inpatient Psychiatric Services (HBIPS) and Perinatal Care (PC) core measure sets that are not common to the Centers for Medicare and Medicaid Services. Selected standardized measure sets have been incorporated in this specifications manual to centralize the measures used for Joint Commission programs into one manual and include Advanced Certification in Heart Failure (ACHF), Advanced Certification in Heart Failure Outpatient (ACHFOP), and Stroke (STK). Measures listed in this manual are Chart-Abstracted Measures.

PRIVATE INSURERS

Each private insurer has its own unique approach to quality assurance and improvement.

- However, the NCQA developed Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 81 measures across five domains of care. http://www.ncqu.org/hedis-quality-measurement.
- In addition, America's Health Insurance Plans (AHIP) has collaborated with CMS and other stakeholders to release (February 2016) seven core sets of quality measures to support quality improvement across the health system. These core measure sets focus on: accountable care organizations; cardiology; gastroenterology; HIV/hepatitis C; medical oncology; orthopedics; obstetrics and gynecology; and pediatrics.