Medicare Quality Reporting
Payment Penalties

The following charts show the Medicare Part A and B quality reporting programs and the penalties for not participating or meeting expectations.

NOTE: Critical Access Hospitals (CAHs) are not required to participate in the Part A reporting at this time. The Part A quality reporting programs affect hospitals that are reimbursed based on the Inpatient Prospective Payment System (IPPS), which is the DRG payment method. CAHs are not reimbursed based on a DRG but on reasonable costs. FQHCs are exempt from Part A quality reporting since they are not a hospital. The following quality reporting programs do not apply to the Medicare Part A IHS outpatient AIR payments.

Part A

Applies to IHS and Tribal Hospitals (excluding CAHs). Reductions will be applied to either the APU or DRG payments.

Program	Year	Penalty %	How It Affects Medicare Payment	Reporting Methods
Hospital Inpatient Quality Reporting (IQR) The Hospital IQR Program requires "sub-section (d)" hospitals (hospitals paid under IPPS) to report data for specific quality measures for health conditions common among people with Medicare, and which typically result in hospitalization. Hospitals report on quality measures through the QualityNet portal; plus CMS retrieves information from processed claims and from patient surveys. An example of these measures include chart-abstracted measures, such as heart attack and surgical care improvement measures; claims-based measures (CMS will retrieve from processed claims) such as mortality and readmissions; healthcare-associated infection measures and survey-based measures, such as patient experience of care.	2015 2016 2017	1.5 Not proposed at this time.	Reduction applied to market basket (Annual Payment Update (APU)). CMS publishes the APU each year in the IPPS Final Report. The APU is the annual percentage increase that CMS applies to Medicare reimbursement for eligible IPPS hospitals. APU is a “base rate” that is then adjusted based on DRG assigned to inpatient claim.	Hospitals submit data quarterly through the CMS QualityNet portal (approved website for secure healthcare quality data exchange). Clinical measures include: • Acute Myocardial Infarction; • Heart Failure; • Pneumonia; • Surgical Care Improvement Project; • Emergency Department; • Immunization; • Stroke; • Venous Thromboembolism; and • Perinatal Care. Hospitals collect and submit HCAHPS survey data quarterly to QualityNet. Structural measures are submitted annually to QualityNet. Submit healthcare associated infections to CDC/National Healthcare Safety Network. Exceptions for hospitals with no ICU.

Program	Year	Penalty %	How It Affects Medicare Payment	Reporting Methods
Hospital Value Based Purchasing (VBP) The VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures. Hospitals will be scored based on how well they perform on clinical and process measures, the patient experience survey and mortality rates among Medicare patients admitted for heart attacks, heart failure or pneumonia. The payment reductions listed in the penalty column will be withheld from all eligible hospitals, but can be earned back as incentives which will be based on performance scores.	2015 2016 2017	1.5 1.75 2	Reduction applied to market basket (APU)	CMS will score hospitals based on an achievement threshold and improvement. Hospitals will be scored on three sets of measures. The first are 13 measures of timely and effective care (also known as process measures (measures that indicate how often hospitals provide certain care that is recommended for patients with heart attack, heart failure, pneumonia, surgery)); the second set is the patient survey (patient experience and satisfaction) and the last set is the mortality rates among Medicare patients admitted for heart attack, heart failure or pneumonia).
Hospital Readmissions Reduction Program CMS will assess hospitals' readmission penalties using five readmissions measures endorsed by the National Qualify Forum (NQF). Hospital Compare reports the following 30-day readmission measures: • Heart attack. • Heart failure. • Pneumonia. • Chronic obstructive pulmonary disease. • Hip/knee arthroplasty.	2015 2016 2017	3 3 3	Reduction applied to DRG payment for every inpatient stay.	CMS uses an ACA-mandated formula to determine each eligible hospital's readmissions performance. The formula calculates an "excess readmission ratio" for each hospital using readmission measures for the clinical conditions in the program, and then translates that ratio into a financial penalty. As of fiscal 2015, the HRRP includes readmission measures for heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and total hip and knee replacements. When calculating each hospital's readmissions performance, CMS excludes patients who had certain planned readmissions, transferred to other hospitals or left against medical advice. However, CMS also includes patients

				readmitted for reasons unrelated to the initial hospital stay. This information was obtained from the American Hospital Association website.
Hospital Acquired Condition (HAC) Reduction Program The HAC Reduction Program, established by the healthcare reform law, penalizes hospitals that fall within the worst-performing quartile, based on measures of adverse events occurring during hospital stays, such as pressure ulcers, pulmonary embolisms and certain types of healthcare-associated conditions (such as central-line associated bloodstream infection and catheter associated urinary tract infection). These are conditions that the CMS has determined the patient did not have upon admission to the hospital but developed during the inpatient stay.	2015 2016	1 Proposed - 1	Reduction applied to DRG payment for every inpatient stay.	CMS determines the HAC score by retrieving data from QualityNet and CDC/National Healthcare Safety Network. The worst performing quartile is identified by calculating a total HAC score which is based on the hospital's performance on three quality measures (Patient Safety Indicator 90 composite, central-line associated bloodstream infection and catheter associated urinary tract infection). Hospitals with a total HAC score above the 75th percentile of the total HAC Score distribution may be subject to payment reduction.

Refer to the QualityNet website for coverage and reporting guidelines regarding the hospital quality reporting programs. www.qualitynet.org

Each State has a Quality Improvement Organization (QIO) that works with hospitals by providing education and assistance on the Part A quality reporting programs. QualityNet has a list of the QIOs and the States they work with:

https://www.qualitynet.org/dcs/ContentServer?cid=1228774346757&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

Hospital scoring will be posted to the Hospital Compare website: https://data.medicare.gov/data/hospital-compare

QualityNet develops "Preview Reports" for hospitals to view the information that will be posted to Hospital Compare:

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228775042385

Part B

Applies to all facilities (including CAHs and FQHCs) that submit Medicare Part B claims (CMS-1500 format) for services reimbursed based on the Physician Fee Schedule. Reductions applied to practitioners Part B payments that are made based on the Physician Fee Schedule.

Program	Year	Penalty %	How It Affects Medicare Payment	Reporting Methods
Physician Quality Reporting (PQRS) PQRS was implemented in 2006 under the Tax Relief and Health Care Act as a temporary incentive payment program for physicians and non-physician practitioners reporting quality measures on the CMS Part B claim. The ACA implemented a payment penalty for eligible practitioners not reporting PQRS. 2014 was the last year for PQRS incentive payments. To avoid the PQRS penalty, eligible practitioners must report on 9 PQRS quality measures, either as individuals or as a group.	2015 2016 2017	1.5 2 2	Reduction to Part B payments (all services reimbursed on the Physician Fee Schedule)	Depending on how to report (either individual or group), submitting PQRS measures can be done through certified EHR technology, a CMS approved Registry or on the CMS-1500 claim form. Reporting through EHR and Registry is only required one time, but facilities must provide PQRS measure data for the full year. If the EHR does not contain measure data for a provider, other means of reporting will be required (i.e. Registry).
Value-Based Payment Modifier (VBPM) The VBPM will be based in part on successfully reporting PQRS measures for each eligible professional in a group. Just like the value-based purchasing in Part A, the Part B value-based payment modifier will be determined based on quality-tiering (or how well a group scores with reporting PQRS). Failure to report PQRS will be an automatic payment reduction from both programs.	2015 2016 2017	Grps. 100 or more - 1% Grps. 10 or more -2% Grps. 10 or more - 4% Grps. 2 to 9 - 2%	Reduction to Part B physician's payment (services reimbursed on the Physician Fee Schedule)	PQRS reported quality measures, along with CMS-calculated outcomes and cost measures are analyzed. CMS assigns groups to their respective quality and cost "tiers" to determine a positive, neutral or negative payment adjustment to the payment based on performance. The adjustment applies to group practices; with CY 2015 penalty applying to groups of 100 or more EPs; CY 2016 penalty applying to groups of 10 or more EPs and by CY 2017 penalty applying to groups of 2 or more.

Refer to the CMS PQRS website for coverage and reporting guidelines. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

QualityNet develops "PQRS Feedback Reports" for each TIN reporting PQRS. https://www.qualitynet.org/portal/server.pt/community/pqri_home/212

Meaningful Use

Hospitals

Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs.

The table below illustrates the application of the reduced update to the acute care hospital IPPS standardized amount.

	2015	2016	2017	2018	2019	2020+
% Decrease	25%	50%	75%	75%	75%	75%

For example if the increase to IPPS for 2015 was 2%, then a Medicare subsection (d) eligible hospital that is not a meaningful user would only receive a 1.5% increase in 2015.

Critical Access Hospitals

Critical Access Hospitals (CAHs) that are not meaningful users will be subject to a payment adjustment for fiscal year 2015. This payment adjustment is applicable to a CAH's Medicare reimbursement for inpatient services during the cost reporting period in which they failed to demonstrate meaningful use. If a CAH has not demonstrated meaningful use for an applicable reporting period, then for a cost reporting period that begins in FY 2015, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent.

The table below illustrates the application of the payment adjustments to CAHs that fail to demonstrate meaningful use.

	2015	2016	2017	2018	2019	2020+
% of reasonable costs	100.66%	100.33%	100%	100%	100%	100%

Eligible Professionals

Eligible professionals who can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs.

Medicare eligible professionals who are not meaningful users (in either the Medicare or Medicaid EHR program) will be subject to a payment adjustment beginning on January 1, 2015.

This payment adjustment will be applied to the Medicare physician fee schedule (PFS) amount for covered professional services furnished by the eligible professional during the year (including the fee schedule amount for purposes of determining a payment based on the fee schedule amount). Eligible professionals receive the payment adjustment amount that is tied to the year that they did not demonstrate meaningful use.

The adjustments begin at 1% for 2015 and increase by 1% each year, until CY 2018 when the reduction will stay at 3% or continue to increase to 5% by CY 2019, based on percentage of eligible providers participating in EHR.

Refer to the CMS Payment Adjustments and Hardship Exceptions Tipsheet for Eligible Professionals:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

Refer to the CMS EHR Incentive Programs website for reporting guidelines regarding meaningful use:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html