American Hospital Association

SPECIAL BULLETIN

Monday, January 10, 2011

CMS Releases Proposed Rule for Hospital Value-Based Purchasing Program

The Centers for Medicare & Medicaid Services (CMS) late Friday, Jan. 7, released a proposed regulation (http://www.ofr.gov/OFRUpload/OFRData/2011-00454_PI.pdf) for the new hospital value-based purchasing (VBP) program.

The Patient Protection and Affordable Care Act of 2010 (ACA) requires the Secretary of Health and Human Services to establish a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program will apply to all acute-care prospective payment system (PPS) hospitals.

Key provisions of the proposed rule are summarized below.

Quality Measures Selected: The rule proposes the quality measures that would be used for the program. For the first year, FY 2013, CMS proposes 17 clinical quality measures as well as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey for inclusion in the VBP program. The clinical quality measures selected include three measures of heart attack care, three measures of heart failure care, four measures of pneumonia care, and seven measures of surgical care. The ACA stipulates that the program include healthcare-associated infection measures. For FY 2013, four of the surgical care measures would fulfill that requirement. By law, the program cannot include the existing readmissions measures because of the separate readmissions payment penalty provision. A full list of the measures proposed for FY 2013 can be found at the end of this *Special Bulletin*.

For FY 2014, CMS proposes to add the heart attack, heart failure and pneumonia mortality measures to the VBP program, as well as nine patient safety and inpatient quality indicators developed by the Agency for Healthcare Research and Quality and eight measures of hospital-acquired conditions.

CMS did not propose to include efficiency measures in the VBP program at this time.

Calculation of Performance Scores: According to the ACA, hospitals will receive the higher of their attainment or improvement score for each measure. For the clinical process measures, CMS proposes to set a minimum achievement threshold for each individual quality measure at the national median score. CMS proposes to set a performance benchmark for each measure at the level of the mean of the top decile of all hospitals' scores on that measure. Thus, hospitals that score at or above the minimum achievement threshold will receive at least some points for attainment, and hospitals that score at or above the benchmark will receive the highest number of points for that measure. Hospitals' improvement scores will be assigned by awarding points based on how the hospital has improved on its performance from a baseline period to the performance period.

CMS proposes that scores for HCAHPS would be calculated similarly to scores for the clinical process measures, but the HCAHPS scores also would include a component for assessing the consistency among the hospital's scores on the individual HCAHPS questions.

To determine hospitals' overall scores, CMS proposes to first group the clinical process measures and the HCAHPS measures into two different "domains." A score would be calculated for each domain by summing the individual measure scores within that domain, weighting each measure equally. Thus, the domain score would equal the percentage of points earned out of the total possible points for which a hospital is eligible.

CMS proposes to then combine the scores for the clinical process and HCAHPS domains to determine a total performance score. For FY 2013, CMS proposes that the domain of the clinical process measures would account for 70 percent of the hospital's score, and the HCAHPS domain would account for 30 percent of the hospital's score.

Beginning in FY 2014, when CMS proposes adding outcomes measures to the VBP program, a third domain would be included in the performance scores to incorporate those measures. CMS will propose the weighting of the three domains in a future rule.

Hospitals Excluded from the Program: Under the ACA, certain hospitals are excluded from the VBP program. First, Maryland hospitals, hospitals located outside the 50 states and the District of Columbia, psychiatric, rehabilitation, long-term care, children's, cancer and critical access hospitals are excluded. Second, the ACA excludes hospitals that do not meet the requirements of the Medicare pay-for-reporting program. Third, the ACA excludes hospitals that have been cited by the Secretary for deficiencies that pose immediate jeopardy

to the health or safety of patients. CMS proposes to define these hospitals as any cited through the Medicare State Survey and Certification process for such deficiencies during the performance period.

Finally, the ACA excludes from the VBP program hospitals with small numbers of applicable patient cases or measures, as defined by the Secretary. For the clinical process measures domain, CMS proposes to exclude from hospitals' scores any measures for which they report fewer than 10 cases. The agency proposes to also exclude from the VBP program any hospitals for which fewer than four of the 17 proposed clinical process measures apply. CMS also proposes to exclude from the VBP program any hospital that reports fewer than 100 HCAHPS surveys during the performance period.

Withholding and Allocating VBP Payment Incentives: Funding for the program will be generated by reducing all inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) operating payments to participating hospitals using a phased-in approach. Payments will be reduced by 1 percent in FY 2013; 1.25 percent in FY 2014; 1.5 percent in FY 2015; 1.75 percent in FY 2016; and 2 percent in FY 2017 and beyond. The reduction will be applied to all MS-DRG operating payments but will not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments. The VBP program is budget neutral; all funds withheld must be paid out to hospitals.

CMS proposes to translate each hospital's total performance score into an incentive payment using a simple linear function. It proposes that all hospitals with scores above zero will receive an incentive payment. CMS does not make any proposals around how the incentive payments will be made (e.g., as discharge add-ons or a lump sum).

The incentives will apply for one year only, and the payment incentives are not carried over as baseline payment rates for the following year.

Implementation Dates: The payment changes will be implemented with hospitals' FY 2013 payments. In that year, for both the proposed clinical process and HCAHPS measures, CMS proposes a baseline period of July 1, 2009 through March 31, 2010, and a performance period of July 1, 2011 through March 31, 2012. In future years for these measures, CMS states that it anticipates proposing to use a full year for the performance period. However, for the mortality measures that CMS proposes to include in the VBP program beginning in FY 2014, the agency proposes a performance period of July 1, 2011 through Dec. 31, 2012, with a baseline period of July 1, 2008 through Dec. 31, 2009.

The ACA requires CMS to notify hospitals of the performance period scores that will be used to determine their VBP incentive payment at least 60 days before FY 2013 begins. Because the proposed performance period would end only six months prior to the beginning of FY 2013, CMS proposes to inform each hospital through its QualityNet account of its *estimated* incentive payment at least 60 days prior to the start of FY 2013 (by Aug. 2, 2012). CMS then proposes to inform each hospital of its *actual* incentive payment for FY 2013 on Nov. 1, 2012.

Data Validation: CMS proposes to apply the existing Medicare pay-for-reporting program data validation process for both the pay-for-reporting and VBP programs.

Demonstration Programs for CAHs and Hospitals with Small Numbers of Cases/Measures: The ACA established two demonstration programs for CAHs and hospitals with an insufficient number of patient cases or applicable measures. The demonstration programs, which also are budget neutral, must begin by March 23, 2012 and will run for a three-year period. CMS did not make proposals around these demonstrations in this rule; we anticipate the agency will release additional information about the demonstrations and how hospitals may apply to participate later this year.

Next Steps

The proposed rule will be published in the January 13 *Federal Register;* a display copy is available at http://www.ofr.gov/OFRUpload/OFRData/2011-00454_PI.pdf. Comments will be accepted through March 8.

Look for an AHA *Regulatory Advisory* containing a more detailed analysis of the proposed rule in the coming weeks.

List of Measures Proposed for Inclusion in FY 2013 Hospital VBP Program

Condition	Measure
Heart attack	Aspirin at discharge
	Fibrinolytic therapy received within 30 minutes of hospital arrival
	Primary PCI received within 90 minutes of hospital arrival
Heart Failure	Discharge instructions received
	Evaluation of LVS function
	ACEI or ARB for LVSD
Pneumonia	Pneumococcal vaccination
	Blood culture performed prior to administration of first antibiotic(s)
	Initial antibiotic selection for CAP in immunocompetent patient
	Influenza vaccination
Healthcare-Associated Infection	Prophylactic antibiotic(s) one hour before incision
	Selection of antibiotic given to surgical patients
	Prophylactic antibiotic(s) stopped within 24 hours after surgery
	Cardiac surgery patients with controlled 6AM postoperative serum glucose
Surgical Care Improvement	Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period
	Surgery patients with recommended venous thromboembolism prophylaxis ordered
	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery
Patient Experience of Care	HCAHPS survey results on patient interaction with doctors, nurses, and hospital staff; cleanliness and quietness of the organization; pain control; communication about medicines; and discharge information