

Quality Incentives: CMS Releases Proposed Rules on Value-Based Purchasing for Hospitals

Comment Period Ends March 8, 2011

The proposed rule regarding Hospital Inpatient Value-Based Purchasing Program was published in the *Federal Register* on January 13, 2011. The public comment period is open until 5 p.m. on March 8, 2011.

On Friday, January 7, 2011, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that would establish a value-based purchasing (VBP) program for acute care hospitals that are paid under the Medicare Inpatient Prospective Payment System (IPPS). CMS has had a long-standing initiative to create a closer linkage between Medicare payments and improvements in the quality of care, including the safety and overall experience of patients. The Affordable Care Act (ACA), Section 3001,

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required CMS to create a value-based program that rewarded hospitals for quality care, rather than only reducing annual market basket updates as a consequence of not reporting on quality measures. These proposed rules provide the initial details that will ultimately transform health care reimbursement to the value-based model many believe is necessary to bend the cost curve and improve quality in the system as a whole.

For some, these changes will represent tremendous opportunities. For organizations that are unable to improve quality and reduce costs, they may mean financial losses.

VALUE-BASED PROGRAM OVERVIEW

The hospital value-based purchasing program is scheduled to go into effect in fiscal year (FY) 2013 (beginning October 1, 2012), and will focus on a hospital's achievement and improvement on specific measures of clinical quality and patient satisfaction. Incentive payments will be based on a nine-month performance measurement period from July 1, 2011, through March 31, 2012. Hospitals that achieve certain performance standards or improve their performance will be eligible to receive an incentive payment beginning on October 1, 2012.

Because incentive payments must be budget neutral, total payments to hospitals can't be increased or decreased. To fund the program, the secretary of Health and Human Services is required to reduce the base operating diagnosis-related group (DRG) payment to each hospital by a specific percentage.

The base operating DRG payment will be derived from the total payments made under Medicare Part A claims data, excluding the following:

- Indirect medical education payments
- Disproportionate share hospital payments
- Low volume hospital adjustment payments

The percentage reduction in base operating DRG payments is scheduled to start at 1 percent for FY 2013, and increase over time to 2 percent as follows:

- FY 2013 1 percent
- FY 2014 1.25 percent
- FY 2015 1.5 percent
- FY 2016 1.75 percent
- FY 2017 and beyond 2 percent

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Clinical Measures

1. Acute Myocardial Infarction

- a. AMI-2 Aspirin Prescribed at Discharge
- b. AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
- c. AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival

2. Heart Failure

- a. HF-1 Discharge Instructions
- b. HF-2 Evaluation of LVS Function
- c. HF-3 ACEI or ARB for LVSD

3. Pneumonia

- a. PN-2 Pneumococcal Vaccination
- b. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
- c. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
- d. PN-7 Influenza Vaccination

4. Healthcare-Associated Infections

- a. SCIP-Inf-1 Prophylactic Antibiotic Required Within One Hour Prior to Surgical Incision
- b. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
- c. SCIP-Inf-3 Prophylactic Antibiotics Discounted Within 24 Hours After Surgery End Time
- d. SCIP-Inf-4 Cardiac Surgery Patients With Controlled 6AM Postoperative Serum Glucose

5. Surgical Care Improvement

- a. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
- b. SCIP-VTE-1 Surgery Patients With Recommended Venous Thromboembolism Prophylaxis Ordered
- c. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

Preliminary calculations by CMS estimates the 1 percent reduction in payments will equate to approximately \$850 million available for value-based incentives in FY 2013.

PROPOSED MEASURES

For FY 2013, CMS has proposed 17 clinical measures (see side bar) and 8 patient care experience measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey items. Most hospitals have been reporting these measures through the Hospital Inpatient Quality Reporting Program (HIQR) for years. However, what will be new is that for the first time, payments will be tied to this data, and thus accuracy of submitted information will be critical to the finances of the organization.

For FY 2014, CMS is proposing to adopt additional measures including three mortality outcome measures, eight hospital acquired condition (HAC) measures, and nine Agency for Healthcare Research and Quality (AHRQ) measures. (These specific measures can be found in the January 13, 2011, *Federal Register*, Section IIC (<http://www.gpo.gov/fdsys/pkg/FR-2011-01-13/pdf/2011-454.pdf>).

CLINICAL MEASURES SCORING

For FY 2013, CMS's scoring system awards points to a hospital for achievement and improvement when compared to two performance thresholds. The achievement threshold will be based on the 50th percentile performance for all hospitals from data obtained in the base line period (July 1, 2009–March 31, 2010). The benchmark threshold represents superior performance and is defined as the mean of the top decile in the same baseline period.

Hospitals will receive 0 to 10 points on a scale that ranges from the achievement threshold to the benchmark threshold. For a hospital to earn any points, it must at least perform at the achievement threshold level. The closer its performance moves toward or above the benchmark threshold the greater the points awarded.

Hospitals will also receive 0 to 9 points for improvement over their prior year's performance. The higher of the two scores (achievement or improvement) from each measure will be used in the hospital's total points for clinical measures.

Once all of the clinical measures are individually scored, they are added together to arrive at the hospital's total points for clinical measures. The total points are then divided by the total possible points, and the result is the hospital's overall clinical measure score.

HCAHPS SCORING

For evaluating a hospital's performance in the eight HCAHPS dimensions, CMS proposes to use the same achievement and benchmark thresholds as for clinical performance. (See HCAHPS Measures table on the following page.) Hospitals will be eligible to receive the higher point totals for either achievement or improvement in each category. This total HCAHPS base score will fall between 0 and 80 points.

CMS has proposed to add a third element—consistency—to the HCAHPS score. The consistency score will enable hospitals to earn 0–20 points based on how many of their HCAHPS dimension scores meet or exceed the achievement threshold. The intent is to create an incentive for hospitals to continually improve their scores in all HCAHPS dimensions to a point where each dimension score is at or above the achievement threshold.

The overall HCAHPS score will be the sum of the base score plus the consistency score, with all dimensions equally weighted.

Fiscal Year (1)	Market Basket Adjustments	2009 Value-Based Purchasing	N/A Coding Offset Adjustment (2)	2009 Hospital Acquired Conditions
2011	0.25%	0%	2.9%	0%
2012	0.20%	0%	2.9%	0%
2013	0.20%	1%	2.9%	0%
2014	0.20%	1.25%	1%	0%
2015	0.20%	1.5%	0%	1%
2016	0.20%	1.75%	0%	1%
2017	0.20%	2%	0%	1%
2018	0.20%	2%	0%	1%
2019	0.20%	2%	0%	1%

HCAHPS Measures

1. Communication With Nurses
2. Communication With Doctors
3. Responsiveness of Hospital Staff
4. Pain Management
5. Communication About Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Overall Rating of Hospital

TOTAL PERFORMANCE SCORE

To arrive at the Total Performance Score (TPS) for each hospital, the scores for clinical and HCAHPS measures are combined. CMS is proposing to weight the two scores: 70 percent to the clinical measures and 30 percent to the HCAHPS measures. Using this methodology, the equation for a hospital TPS is as follows:

$$\frac{(\text{Clinical Measures Score} \times 70\%) + (\text{HCAHPS Score} \times 30\%)}{\text{Hospital TPS}}$$

HOW THE INCENTIVE PAYMENT IS CALCULATED

In accordance with law, the secretary of Health and Human Services is required to make a value-based incentive payment determined by the hospital's performance score and the total amount of incentive dollars available to be paid to hospitals.

CMS is proposing to use a linear exchange formula to convert each hospital's TPS score to a percentage. CMS's intent is to set the slope for the linear exchange function for FY 2013 so the aggregate value of the pool of funds to be distributed will be equal to the 1 percent base operating DRG payment reduction, or approximately \$850 million. Hospitals receiving a score of greater than zero will share in the \$850 million. Those at higher points along the linear slope would receive larger incentive amounts than those on the lower end. Based on CMS's evaluation, the linear exchange formula provides the most straightforward mathematical approach, while also providing all hospitals the same marginal incentive to continually improve quality scores.

CMS anticipates its systems will be capable of distributing incentive payments in January 2013, for discharges effective October 1, 2012.

CHANGE IS GRADUAL; URGENCY IS REQUIRED

The transition to a value-based payment system is at hand, and hospitals will be at the forefront of transforming their delivery systems. While the measurements and indicators are not new, their direct impact on reimbursement is. Beginning in FY 2013 for the first time, hospitals will be rewarded by Medicare for the quality of care provided.

For the first time, payments they receive will be tied to this data, and thus accuracy of submitted information will be critical to the finances of the organization.

The incentive program will be funded through reductions to all hospitals base operating DRG payments, with these reductions being redistributed to those hospitals that demonstrate superior quality. These incentives represent opportunity for those who embrace and demonstrate quality. For others, the demand for continuously improving quality may present financial challenges and possibly reductions in Medicare payments.

The incentive measurement period is scheduled to begin July 1, 2011, and will continue until March 31, 2012. The results will be compared to the base period measurements recorded from July 1, 2009, through March 31, 2010. Quality scores do not change without significant effort, so it is imperative for hospitals to increase their focus on improving their scores now or risk being left out of the incentive pool.

All health care providers should be paying close attention to what hospitals are going through today because, for all practical purposes, it offers a look into the future. Sooner or later all providers will have to address similar quality improvement issues.

The transformation of the reimbursement system to one that rewards quality and cost reduction is a significant step in the right direction to achieving greater value in the health care delivery system. The proposed changes represent only a portion of what will change in the future. To effectively manage the risk to your health care organization, you'll need to be informed, stay engaged, be proactive, and continually strive to improve the way care is delivered.