American Hospital Association

Regulatory Advisory

January 25, 2011

HOSPITAL VALUE-BASED PURCHASING PROGRAM: THE PROPOSED RULE

AT A GLANCE

The Issue:

On January 7, the Centers for Medicare & Medicaid Services (CMS) released a proposed regulation for the new hospital value-based purchasing (VBP) program. The proposed rule, which affects inpatient prospective payment system (PPS) hospitals, is available at http://edocket.access.gpo.gov/2011/pdf/2011-454.pdf and was published in the January 13 *Federal Register*. Comments are due March 8. Major provisions of the rule are described below.

Quality Measures. For fiscal year (FY) 2013, CMS proposes 17 clinical process 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 process measures include three measures of heart attack care, three measures of heart failure care, four measures of pneumonia care and seven measures of surgical care. 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 and eight measures of hospital-acquired conditions.

Calculation of Performance Scores. Hospitals would receive the higher of their achievement or improvement score for each measure. Hospitals that score at least a minimum achievement threshold would receive at least some points for achievement. Hospitals' improvement scores will be assigned by awarding points based on how much the hospital has improved on its performance from a baseline period to the performance period. Scores for the HCAHPS measures would be calculated in a similar fashion and also would include a component for assessing consistency among the hospital's HCAHPS scores.

Hospitals Excluded from the Program. Under the *Patient Protection and Affordable Care Act of 2010* (ACA), 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 from the VBP program. The ACA also excludes hospitals that do not meet the requirements of the Medicare pay-for-reporting program and hospitals that have been cited by the Secretary for deficiencies that pose immediate

(*cont.*)

jeopardy to the health or safety of patients. Finally, the ACA excludes from the VBP program hospitals with small numbers of applicable patient cases or measures.

Withholding and Allocating VBP Payment Incentives. Funding for the program would be generated by reducing all inpatient PPS operating payments to participating hospitals. Payments would be reduced by 1 percent in FY 2013, rising gradually to 2 percent in FY 2017 and beyond. The VBP program is budget neutral, meaning all funds withheld must be paid out to hospitals, and is estimate to redistribute up to $850 million among hospitals in FY 2013. CMS proposes to translate each hospital's total performance score into an incentive payment using a linear scale. It proposes that all hospitals with scores above zero will receive an incentive payment.

Implementation Dates. The payment changes would be implemented with hospitals' FY 2013 payments. For that year, CMS proposes to base hospital scores on their performance from July 1, 2011 through March 31, 2012.

Our Take:

The AHA supports the concept of aligning payment with the delivery of high quality patient care through a pay-for-performance system. While we support the general direction of the rule, we are very concerned about the inclusion of hospital-acquired conditions in the VBP program. Because there is a provision in the ACA that has financial penalties for hospitals with high rates of hospital-acquired conditions, including these same measures in two different parts of the regulation puts hospitals at risk for double jeopardy, or being penalized twice.

What You Can Do:

- ✓ Share this advisory with your senior management team and quality improvement department, as well as your clinical leadership team – including the quality improvement committee and infection control officer – to apprise them of the changes and develop a plan to continually improve your performance on these quality measures.

- ✓ Share the rule's Executive Summary with your Board along with information on where your hospital's performance on the selected measures currently stands.

- ✓ Look for more information from AHA in coming weeks on the potential impact of this provision on your hospital and how to understand what these changes mean for hospital Medicare payment.

Further Questions:

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BACKGROUND

The *Patient Protection and Affordable Care Act of 2010* (ACA) requires the Secretary of Health and Human Services (HHS) to establish a value-based purchasing (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 inpatient prospective payment system (PPS) hospitals. The VBP program is budget neutral, but is estimated to redistribute up to $850 million among hospitals in FY 2013, the first year of the program.

On January 7, the Centers for Medicare & Medicaid Services (CMS) released a proposed regulation for the new hospital VBP program. The proposed rule, available at http://edocket.access.gpo.gov/2011/pdf/2011-454.pdf, was published in the January 13 *Federal Register*. Major provisions of the rule are described below.

AT ISSUE

Selected Quality Measures

The rule proposes quality measures for the program. For FY 2013, CMS proposes to include 17 clinical process measures, as well as the results of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey. The clinical process 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 mandated separate readmissions payment penalty provision. CMS also excludes from the program measures that are "topped out," i.e., measures for which hospital performance is statistically indistinguishable at the 75th and 90th percentiles.

CMS plans to add the 30-day heart attack, heart failure and pneumonia mortality measures in FY 2014. In addition, the agency proposes to add nine patient

safety and inpatient quality indicators developed by the Agency for Healthcare Research and Quality and eight measures of hospital-acquired conditions. The hospital-acquired condition measures are the same ones included in the current inpatient PPS hospital-acquired conditions policy and are identical to the measures defined in another ACA provision that would financially penalize hospitals with high rates of hospital-acquired conditions. The AHA strongly opposes the inclusion of hospital-acquired condition measures in both the VBP program and the hospital-acquired condition policy because of the opportunity for hospitals to be penalized twice on the same measures.

The ACA directs CMS to include measures of hospital efficiency in the VBP program in future years including measures of Medicare spending per beneficiary. CMS does not provide any indication of when it will propose to include such measures, but solicits public comment as to what services should be included and excluded in a Medicare spending per beneficiary calculation. As a note, none of the VBP measures overlap with the measures selected under the meaningful use criteria of the Medicare electronic health records incentive program. A full list of the measures proposed for FYs 2013 and 2014 can be found in the appendix to this advisory.

Calculation of Performance Scores

CMS proposes several steps to calculate hospitals' VBP scores. These steps are detailed below and outlined in Figures 1 and 2.

Determining Scores for the Clinical Process Measures. According to the ACA, hospitals must receive the higher of an "achievement" or "improvement" score for each measure. Thus, CMS proposes a way to evaluate hospitals both on their achievement on each measure during the "performance period" and the improvement in their performance from a "baseline period" to the performance period.

First, CMS would set "performance standards" for each clinical process measure. To do this, CMS proposes establishing a minimum "achievement threshold" that hospitals must meet to receive any points for achievement. CMS proposes that, for each measure, the achievement threshold would be the median score among all hospitals during the baseline period. CMS also proposes a "benchmark" score of the mean of the top decile of all hospitals' scores. All hospitals that meet or exceed the benchmark score during the performance period would receive maximum points for that measure.

Once the performance standards are established, CMS would calculate hospitals' VBP scores on the individual clinical process measures. To calculate achievement scores for each measure, CMS would assign a hospital points along a range between the achievement threshold (the minimum level of hospital performance required to receive achievement points) and the benchmark (the standard at which a hospital would receive the maximum number of points):

- If a hospital's score is equal to or greater than the benchmark, the hospital would receive 10 points for achievement.

- If the hospital's score is less than the achievement threshold, the hospital would receive zero points for achievement.

- If the score is equal to or greater than the achievement threshold but below the benchmark, the hospital would receive a score of 1-9 based on where its score falls on the scale between the achievement threshold and the benchmark according to the following formula:

$$9 \times \left(\frac{\text{performance period score} - \text{achievement threshold}}{\text{benchmark} - \text{achievement threshold}} \right) + 0.5$$

All achievement scores would be rounded to the nearest whole number.

In determining the improvement score, hospitals would receive points along a range between the hospital's score during the baseline period and the benchmark score:

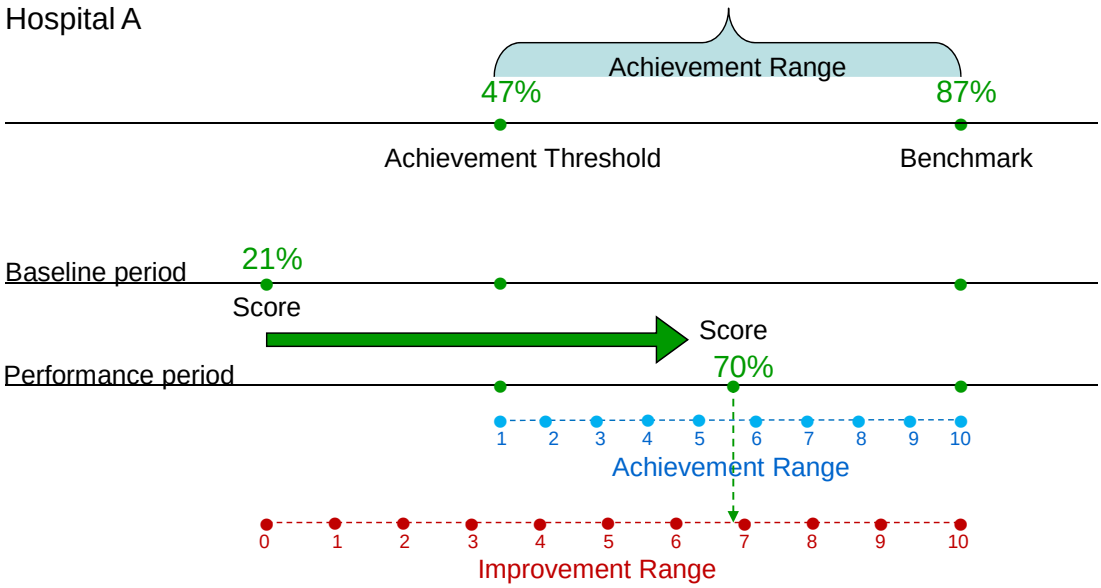
- If the hospital's score is lower than its baseline period score on the measure, the hospital would receive zero points for improvement.

- If the score is greater than the baseline period score but below the benchmark, the hospital would receive from 0-9 points based on where its score falls on its own unique improvement range, according to the following formula:

$$10 \times \left(\frac{\text{performance period score} - \text{baseline period score}}{\text{benchmark} - \text{baseline period score}} \right) - 0.5$$

All improvement scores would be rounded to the nearest whole number.

Figure 1: Sample VBP Scoring for Clinical Process Measure



Hospital A earns 6 points for achievement and 7 points for improvement
Hospital A score = higher of achievement or improvement = 7 points

Determining HCAHPS Scores. CMS proposes that HCAHPS scores be calculated similarly to scores for the clinical process measures, but the HCAHPS scores also would include a component for assessing the hospital's consistency. To assess hospitals on their HCAHPS scores, CMS proposes to use the HCAHPS "dimensions" that are reported on *Hospital Compare* (e.g., the categories for nurse communications, communication about medications, etc.) with two exceptions. First, the agency proposes to combine the "cleanliness" and "quietness" ratings into one category. Second, it proposes not using the "recommend the hospital" item. (The full list of HCAHPS dimensions is included in the measures table in the appendix to this advisory.)

For each HCAHPS dimension, the score would be based on the proportion of best category, or "top-box," responses. For example, the hospital's score on nurse communication would equal the proportion of patients who replied that their nurses "always" communicated well. For each HCAHPS dimension, CMS proposes establishing a minimum achievement threshold equal to the median top-box score among all hospitals during the baseline period. The agency proposes to set the benchmark at the 95th percentile of performance during the baseline period. Note that the HCAHPS benchmark and clinical process measure benchmarks are calculated differently.

To calculate achievement scores for each HCAHPS dimension, CMS would assign a hospital points along the range between the achievement threshold and the benchmark.

- If a hospital's score on a dimension is equal to or greater than the benchmark, the hospital would receive 10 points for achievement.

- If the hospital's score on a dimension is less than the achievement threshold, the hospital would receive zero points for achievement.

- If the score is equal to or greater than the achievement threshold but below the benchmark, the hospital would receive a score of 1-9, rounded to the nearest whole point, based on where its performance falls on a scale between the achievement threshold and the benchmark according to the following formula:

$$\left(\frac{\text{HCAHPS performance period dimension score} - 50}{5}\right) + 0.5$$

To calculate HCAHPS improvement scores, hospitals would receive points along an improvement range, a scale between the hospital's prior score during the baseline period and the benchmark score.

- If the hospital's dimension score is lower than its baseline period score on the measure, the hospital would receive zero points for improvement.

- If the score is greater than its baseline period score but below the benchmark, the hospital would receive a score of 0-9 based on where its performance falls on its own unique improvement range according to the following formula:

$$10 \times \left(\frac{\text{HCAHPS performance period dimension score} - \text{HCAHPS baseline period dimension score}}{\text{benchmark} - \text{HCAHPS baseline period dimension score}}\right) - 0.5$$

CMS proposes to also evaluate hospitals on the consistency of their HCAHPS scores. Hospitals would be able to earn 0-20 points for consistency. To calculate the "HCAHPS consistency score," CMS would assign points based on each hospital's lowest score among the eight HCAHPS dimensions. Specifically, the hospital's lowest score during the performance period would be compared to the hospital's performance during the baseline period, and the hospital would be assigned consistency points, rounded to the nearest whole number, based on the following formula:

$$2 \times \left(\frac{\text{lowest percentile}}{5}\right) - 0.5$$

For example, if a hospital's lowest HCAHPS dimension fell at the 10th percentile of all hospitals' performance during the baseline period, then the hospital would receive (2 x (10 / 5)) – 0.5 = 3.5 consistency points, which would round up to 4 points. If the hospital's scores on all eight dimensions were above the 50th percentile of the baseline period, the hospital would earn the maximum 20 points.

Determining Total Performance Scores. In determining hospitals' overall scores, CMS proposes first to group the clinical process measures into one "domain" and the HCAHPS dimensions into another "domain." A score would be calculated for each domain by summing the individual measure scores within that domain, weighting each measure equally. For the clinical process measures, the score for each domain would be based only on the measures that apply to that hospital (i.e., those for which the hospital treats at least the required minimum number of 10 cases). CMS proposes that the hospital's total points for the domain would then be divided by that hospital's total points possible for the domain, which equals the total number of domain measures that apply to that hospital, multiplied by 10 points. The resulting percentage would be multiplied by 100 to obtain the hospital's score for that domain.

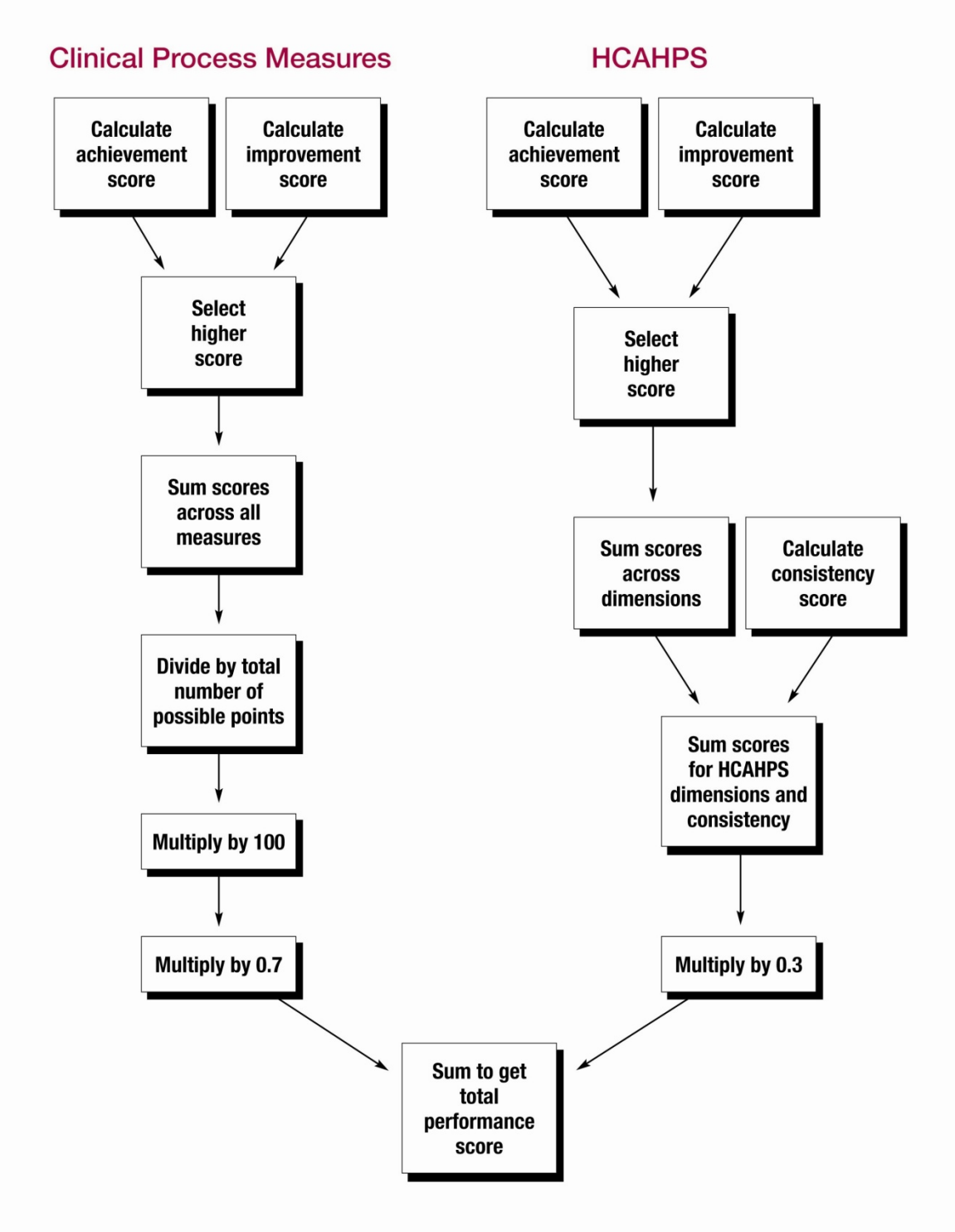
For example, if a hospital had five applicable clinical process measures and scored 5, 7, 3, 9 and 10 on those individual measures, CMS would first add those scores to obtain 34 points for the clinical process domain. It would then divide that number by the total points possible for the clinical process domain, which is 50 (five applicable measures times 10 points). The result is 68 percent, which CMS would multiply by 100 to obtain a score of 68 for that hospital on the clinical process domain.

In addition, CMS proposes to group the HCAHPS dimensions into a second domain. To calculate this score, CMS would add the individual HCAHPS dimension scores (eight dimensions each worth a maximum of 10 points) with the HCAHPS consistency score (worth a maximum of 20 points) to get the hospital's total points out of a possible 100 points.

CMS proposes to then combine the scores for the different domains to determine a total performance score. For FY 2013, CMS proposes that the clinical process measure domain 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 score to incorporate those measures. CMS is soliciting comment on how to account for the score of the outcomes measure domain.

Figure 2: Flowchart of How Total Performance Scores Would Be Calculated



Hospitals Excluded from the Program

Under the ACA, certain hospitals are excluded from the VBP program. First, non-subsection (d) hospitals are excluded. CMS proposes to define non-subsection (d) hospitals as those outside the 50 states or the District of Columbia, psychiatric, rehabilitation, long-term care, children's, cancer and critical access hospitals (CAHs). In addition, although hospitals in Maryland are considered subsection (d) hospitals, under the ACA, they are exempt from the VBP program so long as the state submits an annual report describing how a similar state program achieves similar goals (which it plans to do).

Second, the ACA excludes hospitals that do not meet the requirements for the Medicare pay-for-reporting program, that is, hospitals that receive a payment penalty under the pay-for-reporting program. CMS notes in the rule that it is concerned about the possibility of hospitals essentially "opting out" of the VBP program by choosing not to submit data for the pay-for-reporting program; therefore, the agency states that it will track hospital participation in the pay-for-reporting program. Although the AHA has asked CMS to clarify the relationship between the VBP program and the pay-for-reporting program, it did not do so in this rule.

Third, the ACA excludes hospitals that have been cited by the HHS 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.

For hospitals that have data for the performance period, but not for the baseline period (such as if the hospital was not open or did not participate in the pay-for-reporting program during the baseline period), CMS proposes to include them in the VBP program, but only evaluate them on achievement – not on improvement.

Witholding and Allocating VBP Payment Incentives

Funding for the program will be generated by reducing all "base" 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 base MS-DRG operating payments but will not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments. CMS states that it will propose a more specific definition of base operating payments in future rulemaking.

The VBP program is budget neutral, meaning all funds initially withheld must be paid out to hospitals. The incentives will apply for one year only and are not carried over to baseline payment rates for the following year. Incentives will be both calculated and paid based on the provider number used for cost reporting purposes, the CMS Certification Number.

CMS proposes to translate each hospital's total performance score into an incentive payment using a simple linear scale. Although CMS considered several types of curved scales, it states that the linear scale was the most simple and provides all hospitals with the same marginal incentive to continually improve. It does, however, solicit public comments on its proposed linear scale and the resulting distribution of incentive payments.

While CMS proposes that all hospitals with scores above zero receive an incentive payment, it did not specify the exact linear scale it will use to translate a hospital's performance score into its incentive payment. The agency also did not specify what the maximum incentive payment will be or what performance score will be necessary receive the maximum incentive payment. Such details will need to be calibrated to maintain the budget neutrality of the program, and we anticipate CMS will propose these details at a later time.

Finally, CMS did not make any proposals around how the incentive payments will be made (e.g., as discharge add-ons or a lump sum).

Implementation Dates

The VBP payment changes will be implemented with hospitals' FY 2013 payments. For that year, for both the clinical process and HCAHPS measures, CMS proposes a nine-month baseline period of July 1, 2009 through March 31, 2010, and a nine-month performance period of July 1, 2011 through March 31, 2012. CMS proposes a baseline period that is two years prior to the performance period. It does so because, under the ACA, it must announce the standards that will be used to assess hospitals' performance at least 60 days before the performance period begins – or by May 2, 2011. Data from a baseline period of July 1, 2010 through March 31, 2011 would not be available in time to calculate and announce the performance standards by May 2, 2011. In future years, CMS states that it anticipates proposing 12-month baseline and performance periods for the clinical process and HCAHPS measures.

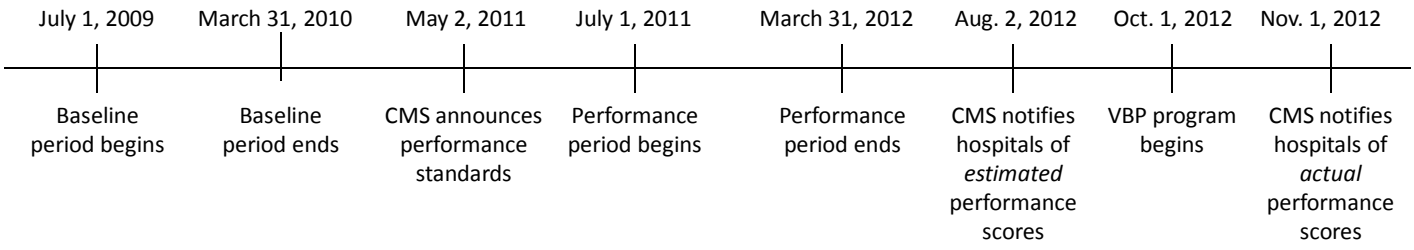
For the mortality measures that CMS proposes to include in the VBP program beginning in FY 2014, the agency proposes a performance period of July 1, 2011 through Dec. 31, 2012, with a baseline period of July 1, 2008 through Dec. 31,

2009. This time period is shorter than the current three-year period used for the *Hospital Compare* data display; however, CMS noted in the proposed rule that their analysis showed that using 18 months of data led to reliable data calculations.

The ACA requires CMS to notify hospitals of the performance scores that will be used to determine their VBP incentive payment at least 60 days before FY 2013 begins, or by August 2, 2012. Because CMS proposes a nine-month performance period (as opposed to six months or less), the performance period would end only six months prior to the beginning of FY 2013, and CMS will not have final performance scores by then. Therefore, the agency proposes to inform each hospital through its QualityNet account of its *estimated* incentive payment by August 2, 2012. CMS would then inform each hospital of its *actual* incentive payment for FY 2013 on November 1, 2012.

For a timeline of all steps in the VBP process for FY 2013, see Figure 3.

Figure 3: Fiscal Year 2013 Proposed VBP Timeline



Public Reporting

The ACA requires CMS to make publicly available hospital-specific performance information on individual measures, conditions or procedures, and overall scores. To do so, CMS proposes to publish on the *Hospital Compare* website hospital-specific information with respect to individual measure scores, condition-specific scores, domain-specific scores and total performance scores.

Data Review, Appeals and Validation

CMS proposes to use the 30-day data preview period established for the Medicare pay-for-reporting program as the mechanism through which hospitals can review their VBP data and submit corrections prior to its publication.

The ACA requires CMS to establish an appeals process through which hospitals may seek reconsideration of the calculation of their performance assessment with respect to the performance standards and their performance score. CMS plans to propose such a process in future rulemaking and asks for comments on the structure of an appropriate appeals process.

CMS proposes to apply the existing Medicare pay-for-reporting program data validation process for both the pay-for-reporting and VBP programs. Under this process, 800 hospitals are selected each year and asked to submit approximately 50 medical records for data validation.

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

Given the major changes proposed in this rule, the AHA encourages hospital leaders to estimate the impact of the provisions on their facilities. Evaluate your performance on the quality measures by comparing your performance on *Hospital Compare* to your state and the national averages. Look for more information from AHA on the impact of the VBP program, including its potential impact on your hospital and upcoming member conference calls.

Appendix

List of Measures Proposed for Inclusion in FY 2013 and 2014 Hospital VBP Program

FY 2013	
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
HCAHPS Patient Experience with Care Survey	Communication with nurses
	Communication with doctors
	Responsiveness of hospital staff
	Pain management
	Communication about medicines
	Cleanliness and quietness of hospital environment
	Discharge information
	Overall rating of hospital

FY 2014	
Condition	**Measure**
Mortality	30-day heart attack mortality
	30-day heart failure mortality
	30-day pneumonia mortality
Patient Safety Indicators/Inpatient Quality Indicators	Iatrogenic pneumothorax, adult
	Post operative respiratory failure
	Post operative pulmonary embolism or deep vein thrombosis
	Post operative wound dehiscence
	Accidental puncture or laceration
	Abdominal aortic aneurysm repair mortality rate (with or without volume)
	Hip fracture mortality rate
	Complication/patient safety for selected indicators (composite)
	Mortality for selected conditions (composite)
Hospital-Acquired Conditions	Foreign object retained after surgery
	Air embolism
	Blood compatibility
	Pressure ulcers stages III and IV
	Falls and trauma (Includes: fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
	Vascular catheter-associated infections
	Catheter-associated urinary tract infections
	Manifestations of poor glycemic control