

VALUE-BASED PURCHASING: QUESTIONS AND ANSWERS:

CMS Proposed Rule

Feb. 1, 2011

INTRODUCTION:

The federal government’s long-held philosophy of paying hospitals for providing services to Medicare patients is changing. It is no longer enough for hospital providers to simply report and document that services were provided. With the issuance of CMS’ proposed rule addressing the Value-Based Purchasing (VBP) methodology, hospitals will be required to prove that the quality of care provided (and their patients’ perceptions of that care) meet or exceed national standards. To get paid requires more than just “doing”; it requires “doing it well.” Hospitals that fail to meet those standards will see payment reductions.

On Jan. 7, the Centers for Medicare & Medicaid Services (CMS) put on display its highly anticipated proposed rule addressing implementation of a Medicare Value-Based Purchasing System, which was then published in the *Federal Register* on Jan. 13. This is the first step of what is expected to be a series of rules designed to convert the Medicare program from simply a payer of services provided to a payer of *quality* services provided. While the proposed rule indicates that these payment adjustments are effective beginning on Oct. 1, 2012, given the long-range CMS plans of integrating mortality measures (in FFY2014) and additional measurements in the future, this is expected to be a permanent Medicare payment adjustment for hospitals. Other quality measurements such as readmission rates will eventually factor into the payment formulas as well. In addition, with CMS’ emphasis on quality of care, it is expected that other provider services, including post-acute and outpatient services, will see their current Medicare payments similarly adjusted.

In anticipation of many questions, comments and concerns from our members, IHA has prepared this “FAQ” document for your information. Also, IHA will be sending estimates of specific impacts of the rule to members. These are only estimates, as several provisions in the proposed rule may change based on comments from the field; those changes would be reflected in the final rule, anticipated to be published in late spring or early summer. In addition, the use of more current data (i.e., estimated DRG payments in 2013 subject to the 1% pool) will affect those estimates. Based on IHA estimates prepared in accordance with the VBP model in the 2007 CMS Report to Congress, the 1% total payment pool for Illinois hospitals was estimated at approximately \$41 million.

While the financial impact of this rule does not impact hospitals until FFY2013, hospitals should prepare for implementation now. This should include internal processes such as evaluating how your hospital currently rates in terms of process measures and patient satisfaction, estimating the financial impact on Medicare revenues, and preparing comments for CMS. Since this is a patient care quality-driven rule, physicians’ and case managers’ input is also important.

QUESTIONS & ANSWERS REGARDING THE VALUE-BASED PURCHASING RULE

Integration of payment and quality

(Q) Where can I find the rule?

(A) The rule can be accessed through the following link:

<http://www.gpo.gov/fdsys/pkg/FR-2011-01-13/pdf/2011-454.pdf>

(Q) What is the rationale behind implementation of Value-Based Purchasing?

(A) The hospital value-based purchasing program continues a longstanding effort by CMS to forge a closer link between Medicare's payment systems and improvement in health care quality, including the quality and safety of care in the inpatient hospital setting. In recent years, CMS has undertaken several initiatives, including demonstrations and quality reporting programs, to lay the foundation for rewarding health care providers and suppliers for the quality of care provided. This is achieved by tying a portion of Medicare payments to performance on quality measures. The transition of these initiatives to value-based purchasing is intended to transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive. The hospital VBP program is one of multiple reforms that are dramatically changing how Medicare pays hospitals. Other changes include incentives for implementing electronic health records and additional payment adjustments based on hospitals' rates of hospital-acquired conditions and readmissions.

(Q) What is the basis for CMS' authority to establish and implement this program?

(A) The Deficit Reduction Act of 2005 instructed CMS to design a plan for the structure and implementation of a Value-Based Purchasing system. In accordance with that directive, CMS published a Report to Congress on its plans for the VBP system in November 2007. Section 3001 of the Affordable Care Act requires CMS to implement a hospital value-based purchasing program that rewards hospitals for the quality of care provided as demonstrated by their performance or improvement on measures of care quality beginning in FFY2013. The VBP implementation is one step further than the current payment adjustment system that simply reduces payments to providers for failing to report on selected quality measures.

(Q) What is the general framework of the system?

(A) CMS' rule includes proposed measures for the hospital value-based purchasing program, proposed performance standards for the program, a proposed scoring scheme, and proposals for translating these scores into VBP-based incentive payments for hospitals in FFY2013. Under the program, CMS would

evaluate a hospital's performance during a specific performance period based on achievement or improvement as compared to performance standards established for the program. Hospitals that achieve certain performance standards during this performance period or that improve their performance when compared to a baseline period would receive incentive payments ("re-distributions") for Medicare acute care discharges occurring on or after Oct. 1, 2012.

(Q) Which providers are affected?

(A) At this time, only inpatient, acute care hospitals paid under Medicare's Prospective Payment System are subject to the incentives provided under the Value-Based Purchasing System. It is expected that other hospitals (such as Critical Access Hospitals, Children's Hospitals or Long-Term Care Hospitals), as well as post-acute providers (such as Rehabilitation Hospitals, Skilled Nursing Facilities or Home Health Agencies) will be brought into the system in the future. In addition, hospitals with an insufficient volume of cases (less than 10) to calculate a meaningful process or HCAHPS score are excluded.

(Q) What quality measurements will be used?

(A) CMS is using select measurements that have been publicly reported on *Hospital Compare*. In the first year, the measurements will include 17 process measurements on heart failure, heart attack, pneumonia, and surgical care, and eight measurements from HCAHPS (patient satisfaction). In the second year, Medicare proposes to add 20 new measurements which will be derived from claims data such as 30-day mortality rates; hospital-acquired conditions, and quality and patient safety measurements using the Agency for Healthcare Research and Quality methodology. Please refer to the attached matrix on the proposed measurements for Value-Based Purchasing.

Scoring Methodology

(Q) What are the major components that will determine a specific hospital's rewards or penalties under this system?

(A) Initially, a hospital's financial impact will be determined based on an analysis of four components: (1) Base operating DRG payments to determine its contribution to the VBP "pool" of dollars available; (2) Process Measures Score (PM); (3) Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) Score; and (4) Overall Composite Score. The overall VBP score is comprised of 70% of the Process Measures score and 30% of the HCAHPS score. So for any hospital, $.7 \times \text{PM score} + .3 \times \text{HCAHPS score}$ equals the VBP composite score. Beginning in FFY2014, a hospital's specific outcome scores reflecting mortality rates for heart attack, heart failure and pneumonia will be incorporated.

(Q) How is the VBP system financed by hospitals?

(A) As required by the Affordable Care Act, the hospital VBP program will be budget-neutral, with all funds distributed in the same year they are collected. A pool of funds to be redistributed to hospitals based on quality performance will be funded through an across-the-board reduction to the IPPS standardized DRG amounts. The DRG percentage reduction is 1.0% in FFY2013, increasing by 0.25% each year until the reduction reaches a maximum of 2.0% for FFY2017 and subsequent years.

(Q) What comprises the IPPS standardized amounts that fund the pool?

(A) The 1% of IPPS payments specific to a hospital is made up of base operating DRG payments taken from an estimate of FFY2013 payments. Those total estimated payments are reduced by the additional payments hospitals receive for outliers, capital, low-volume adjustments, indirect medical education or disproportionate share, as none of these adjustments are included in the 1% pool.

(Q) What are “Topped Out” Measures and how do they impact a hospital’s score?

(A) CMS assigns scores to “Topped Out” measures. In theory, as a hospital’s performance on a measure improves, the values of both the benchmark and the attainment threshold would increase. For these measures, all but a few reporting hospitals achieve similarly high performance level results. CMS believes that including the topped out measures would mask true performance comparisons among hospitals. Therefore, those seven measures (AMI-1, Aspirin at Arrival; AMI-5, Beta Blocker at Discharge; AMI-3, ACEI or ARB at Discharge; AMI-4, Smoking Cessation; HF-4, Smoking Cessation; PN-4, Smoking Cessation; and SCIP-Inf-6, Surgery Patients With Appropriate Hair Removal) are not included in the list of proposed measures for use in 2013.

(Q) How are the Process Measures scored?

(A) The scoring for Process Measures will consist of comparing two scores—one for attainment and one for improvement. To calculate the attainment score, a hospital’s performance in the scoring year is compared to the national benchmark (mean performance score for top 10%) and national threshold (50th percentile for all) for each measure. A hospital achieves an attainment score when its performance in the scoring year is above the national threshold for a certain measure; the closer the performance is to the national benchmark, the higher the attainment score. If a hospital’s performance during the scoring year is above the national benchmark, the hospital will receive a score of 10. If a hospital’s performance during the scoring year is below the national threshold, the hospital will achieve a score of 0. If a hospital’s performance is between the national benchmark and threshold, a score between 0 and 10 is calculated and assigned, according to a linear function. The formula for this calculation is found at the bottom of page 2,466 of the rule.

To achieve the improvement score, a hospital's performance for a certain measure must improve from the base year to the scoring year. For each measure, an improvement score of 0-9 is calculated by comparing a hospital's performance in the scoring year to the range between the national benchmark (median performance score for top 10%) and the hospital's performance in the base year. A hospital scoring equal to or lower than its baseline period score on a measure would receive 0 points for improvement. The formula for this calculation is found on page 2,467 of the rule.

The final Process Measures score by line item is the higher of the attainment score or the improvement score. The total score for the Process Measures equals the sum of all your hospital's Final Scores divided by the total of all computed line items.

(Q) How are the HCAHPS measures scored?

(A) The methodology for calculating attainment and improvement scores for the HCAHPS indicators is similar to the methodology for the Process Measures described above. One additional consideration in the HCAHPS scoring is "consistency," which measures whether hospitals are meeting the achievement thresholds established for all eight measures in this category.

Hospitals would receive the higher of the attainment score or the improvement score for each measurement. The main difference from the Process Measures methodology described above is that for each HCAHPS indicator, the national benchmark is set at the 95th percentile and the national threshold is set at the 50th percentile (in contrast, for each process measure, the national benchmark represents the median performance score for the top 10% and national threshold represents the mean for all for each measure). A hospital will receive 1-9 points if it exceeds the 50th percentile threshold; if its score on one of the measures is below 50%, it receives a score of 0 for that category. For improvement, a hospital would receive a score of 0-9 based on comparison of its performance results with its baseline. Consistency points, ranging from 0-20, will be given to a hospital based on how many of its scores meet or exceed the thresholds.

IHA recognizes that these explanations may be confusing; within the next few weeks, we will develop estimates of the detailed calculations for affected hospitals.

(Q) Are there examples of the various calculations?

(A) The rule contains examples of how the scoring will be determined, beginning on page 2,467.

(Q) How is a specific hospital's composite score determined?

(A) An overall VBP score is calculated by combining a hospital's process measure score and HCAHPS indicator score. An overall VBP score is made up of 70% of the total process measure score and 30% of the total HCAHPS score.

(Q) How will hospitals be notified of their pool contribution amounts, their composite score and their portion of the pool redistribution?

(A) Hospital scores on Process Measures and HCAHPS will be available on the *Hospital Compare* website. The proposed rule indicates that hospitals will receive notification of their 1% IPPS reduction amount in the FFY2013 acute inpatient Medicare final rule, usually published in late July or early August. The expectation is that this reduction would be implemented for claims processed beginning Jan. 1, 2013. Hospitals would be notified of **estimates** of their redistribution payment via *QualityNet* no later than Aug. 1, 2012, with **final** amounts communicated on Nov. 1, 2012. According to the proposed rule, specific information on the redistribution is not expected to be publicly displayed in the *Federal Register*.

(Q) Is there more information on the linear function scoring methodology used when a hospital's performance scores falls between the benchmark and the threshold? How are scores within a specific range (such as 0-9) assigned?

(A) IHA will be requesting more information on this as part of its comment letter to CMS. CMS does point out the importance of transparency for hospitals, patients and other stakeholders. The proposed rule suggests that these scores will be assigned using the linear distribution function, and the algebraic formulas used to derive those score are given in the rule.

(Q) Do we know how a specific hospital's redistribution amount will be calculated?

(A) The specifics of the methodology are not clear from the proposed rule; we know that the linear method will be used. Hospitals with composite scores below 0 will receive no award, while those above 0 will receive some award. There will be both "winners" and "losers" when the individual award amount is compared to the dollars put in the pool.

(Q) Will hospitals have the opportunity to review and appeal results before Medicare makes a final determination on the award?

(A) For the first year, CMS is proposing that hospitals be notified of their estimated performance scoring and value-based incentive amounts 60 days prior to the beginning of FFY2013. However, CMS will be unable to make a final determination at that time since they are including claims through March 31, 2012, so the agency proposes to provide final notification to providers on Nov. 1, 2012. CMS will make adjustments to payments in its claims processing system in

January 2013, but those adjustments will be applied retroactively to discharges occurring on or after Oct. 1, 2012. The operational aspects of the claims adjustments will be announced in the FFY2013 final inpatient rule. While the proposed rules are silent on subsequent fiscal year determinations, Medicare is expected to make final determinations 60 days before the beginning of the federal fiscal year.

CMS has indicated that it will have an appeals process, but is seeking feedback on an agency-level appeals process where CMS staff with expertise in the Hospital Value-Based Purchasing program would decide the appeal.

(Q) How and where will hospitals be able to view their results and incentive determination?

(A) CMS will notify providers of estimated and final scores and financial determinations through each hospital's *QualityNet* account. Every hospital that currently submits performance measurement data has a *QualityNet* account where CMS provides all measurement results and previews of *Hospital Compare* information. If you are unsure about the primary and backup account holders for *QualityNet*, you may want to contact your hospital's quality improvement staff. The *QualityNet* approach for review of performance results and previews of public information has been used for several years. Primary and backup account holders are encouraged to check their *QualityNet* mail boxes several times a week so they don't miss any important information.

(Q) Is the process that CMS is applying with the Hospital VBP program similar to other VBP programs for other providers?

(A) CMS is seeking to eventually include value-based purchasing in all of their provider programs. The final rules on a VBP for End Stage Renal Dialysis (ESRD) were made available on Dec. 29, 2010. While there were similarities such as awards based on achievement and improvement measurements and scoring methodologies, differences included a penalty but no reward incentive in the ESRD program.

Next steps in the proposed rule to final rule process

(Q) The proposed rule has been published; what can we expect from CMS over the next several months, assuming the process will follow CMS' normal course of review?

- (A)
- Issuance of proposed rule, with comment period through Mar. 8.
 - Review of comments by CMS. CMS likely will receive several hundred comments; the more comments received, the more time it takes to analyze them.

- Issuance of the final rule by CMS (including analysis of comments). If a large volume of comments is received, a final rule release date as late as July or August is possible. There was a similar lengthy period of time between the end of the comment period and the release of the final rule regarding the Medicare Health Information Technology “meaningful use” provisions and the incentive payments/penalties methodologies.
- It is also likely that CMS could issue an “Interim Final Rule with Comment Period,” which would let the implementation process begin, while allowing for additional public comments on certain provisions of the rule.

Impact of Post-Payment Reviews

(Q) How will post-payment audits of future Medicare claims affect the VBP payment process?

(A) As the VBP incentive payment is expected to be an “add-on” payment to the base DRG payment amount, any claim denials resulting from audits, such as the Recovery Audit Contractor review, will effectively return these dollars back to the Medicare program, along with the initial DRG payment. Conversely, it is expected that if a post-payment review results in the determination of an “underpayment to the hospital,” additional VBP dollars would be reimbursed as well. It is not known at this time (and this will be another issue raised in IHA’s comment letter to CMS) whether a hospital will receive a “credit” for denied claims against the original amount charged to that hospital as part of the pooled amount.

IHA contact staff

(Q) Who should I contact at IHA if I have any further questions or comments?

(A): Please contact either of the following individuals:

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- Mr. Tom Jendro, Senior Director of Finance, (630-276-5516 or tjendro@ihastaff.org)

PROPOSED VALUE BASED PURCHASING

Performance Measurements

MEASUREMENT	Payers Included		Source of Data	
	Medicare Only	All Payers	Clinical Abstract	Claims
Federal Fiscal Year 2013 - Discharges July 1, 2011 – March 31, 2012				
<i>Heart Attack</i>				
AMI-2 Aspirin Prescribed at Discharge		X	X	
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival		X	X	
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival		X	X	
<i>Heart Failure</i>				
HF-1 Discharge Instructions		X	X	
HF-2 Evaluation of LVS Function		X	X	
HF-3 ACEI or ARB for LVSD		X	X	
<i>Pneumonia</i>				
PN-2 Pneumococcal Vaccination		X	X	
PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital		X	X	
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient		X	X	
PN-7 Influenza Vaccination		X	X	
<i>Surgical Care Improvement Program</i>				
SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision		X	X	
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients		X	X	
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time		X	X	
SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose		X	X	
SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period		X	X	
SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered		X	X	
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24				

Hours After Surgery		X	X	
MEASUREMENT	Payers Included		Source of Data	
	Medicare Only	All Payers	Clinical Abstract	Claims
<i>HCAHPS Patient Experience of Care Measures</i>				
Communication with Nurses				
Communication with Doctors		X	X	
Responsiveness of Hospital Staff		X	X	
Pain Management		X	X	
Communication About Medicines		X	X	
Cleanliness and Quietness of Hospital Environment		X	X	
Discharge Information		X	X	
Overall Rating of Hospital		X	X	
Federal Fiscal Year 2014				
<i>30-day Mortality Rate</i>				
Acute Myocardial Infarction (AMI)	X			X
Heart Failure (HF)	X			X
Pneumonia (PN)	X			X
<i>Hospital Acquired Condition Measures</i>				
Foreign Object Retained After Surgery	X			X
Air Embolism	X			X
Blood Incompatibility	X			X
Pressure Ulcer Stages III & IV	X			X
Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)	X			X
Vascular Catheter-Associated Infections	X			X
Catheter-Associated Urinary Tract Infection (UTI)	X			X
Manifestations of Poor Glycemic Control	X			X
<i>AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures</i>				
PSI 06 Iatrogenic pneumothorax, adult	X			X
PSI 11 Post Operative Respiratory Failure	X			X
PSI 12 Post Operative PE or DVT	X			X

PSI 14 Post Operative wound dehiscence	X			X
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MEASUREMENT	Payers Included		Source of Data	
	Medicare Only	All Payers	Clinical Abstract	Claims
PSI 15 Accidental puncture or laceration	X			X
IQI 11 Abdominal aortic aneurysm (AAA) repair mortality rate (with or without volume)	X			X
IQI 19 Hip fracture mortality rate	X			X
Complication/patient safety for selected indicators (composite)	X			X
Mortality for selected medical conditions (composite)	X			X