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Hospital Pay-for-Quality Has Arrived: Final Value-Based Purchasing Rule Released

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On May 6, 2011, the Centers for Medicare and Medicaid Services (CMS) published its Hospital Inpatient Value-Based Purchasing (VBP) program Final Rule [PDF] in the Federal Register with some modifications from the Proposed Rule [PDF]. CMS estimates that it will redistribute an estimated $850 million in hospital DRG payments to reward acute care hospitals based on their overall performance on designated quality measures in the VBP program's first year, fiscal year (FY) 2013. Hospitals should be aware that the performance period for the FY 2013 VBP program begins on **July 1, 2011** and ends on March 31, 2012. CMS will notify hospitals of their estimated performance scores and estimated value-based incentive adjustment amounts for FY 2013 discharges at least 60 days prior to October 1, 2012. However, CMS will not provide notification to hospitals of the exact amount of their value-based incentive adjustments until November 1, 2012. CMS acknowledged that certain quality measures that CMS initially proposed were "topped out" and such measures were excluded from the Final Rule. Below is a summary of the quality measures, performance scores and VBP incentive payments.

Quality Measures

Of the 18 quality measures initially proposed, CMS adopted 12 clinical process of care measures and the HCAHPS measure for inclusion in the FY 2013 VBP program. These measures are described in the chart below:

Final Measures for FY 2013 Hospital VBP program

Clinical Process of Care Measurers	
Acute Myocardial Infarction	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	
HF-1	Discharge Instructions
Pneumonia	
PN-3b	Blood Cultures Performed in the Emergency Department prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent patient
Healthcare-Associated Infections	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 hours After Surgery
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose

Surgeries	
SCIP-Card-2	Surgery Patients on Beta Blocker Prior to Arrival That Received Beta Blocker During the Perioperative :Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience of Care Measurers	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers Systems and Survey

Notably, CMS excluded measures it initially proposed because CMS subsequently determined that the measures were "topped out," and there was no room for improvement for the vast majority of hospitals. In addition, two of the proposed measures – PN-2 (Pneumococcal Vaccination) and PN-7 (Influenza Vaccination) – were not finalized because they are being retired from the Hospital Inpatient Quality Reporting (IQR) program. CMS will no longer require hospitals to submit data on these measures beginning with January 1, 2012 discharges.

CMS appears to have an increasing interest in reduction of hospital acquired conditions (HAC) beyond the Hospital Acquired Conditions Program. Despite receiving numerous comments urging CMS not to include proposed HAC measures in the second year of the VBP program, CMS finalized its proposals to add 8 HAC measures for the FY 2014 VBP program. The addition of HACs in the VBP may be seen as a redundancy since hospitals already face reimbursement consequences for HACs under that quality program. Also, for the FY 2014 program

year, CMS finalized its proposal to adopt several additional outcome-based measures, including (1) three publicly-reported 30-day mortality claims-based measures (Mort-30-AMI, Mort-30-HF, Mort-30-PN) and (2) two composite AHRQ Patient Safety Indicator and Inpatient Quality Indicator measures.

Performance Scores

For purposes of determining a performance score under the VBP program, CMS categorizes the quality measures into key "domains." CMS will calculate hospital performance by evaluating not only the hospital's achievement, but also improvement and/or consistency in meeting quality measure thresholds and benchmarks across these domains. For FY 2013, CMS adopted just two domains – clinical process of care and patient experiences of care. An outcomes domain is added for the FY 2014 VBP program. The following scoring methodologies apply:

- *Clinical Process of Care Domain:* For each measure, a hospital will receive points based on the higher of (1) an achievement score or (2) an improvement score.

  A hospital will receive achievement points only if it exceeds the achievement performance standard (i.e., 50th percentile of all hospital performance nationally during the baseline period) based on its performance during the performance period of July 1, 2011 through March 31, 2012. Hospitals can increase their achievement score based on higher levels of performance up to an achievement benchmark (i.e., the mean of the top 10 percent of all hospital performance nationally during the baseline period). Notably, some measures do not meet CMS criteria for "topped out" measures, but still have an achievement benchmark of 100 percent. Accordingly, a single errant patient case may prevent hospitals from receiving all available achievement points for these quality measures.

  Improvement points are awarded based on the individual hospital's performance as compared to its performance during the baseline period of July 1, 2009 through March 31, 2010.

- *Patient Experiences of Care Domain:* Similar to the clinical process of care measures, CMS will calculate both an achievement score and improvement score, and take the higher of the two scores. In addition, hospitals can receive up to 20 extra "consistency" points that recognize and reward consistent achievement across HCAHPS dimensions.

- *Outcomes* Domain: Beginning in the FY 2014 VBP program year, similar to the clinical process measures, a hospital will receive points based on the higher of (1) an achievement score or (2) an improvement score. Improvement points are awarded based on hospital performance during the performance period of July 1, 2011 to June 30, 2012, as compared to the baseline period of July 1, 2009 through June 30, 2010.

For FY 2013, CMS will calculate an overall VBP score by combining the clinical process of care domain score and the patient experience of care domain score. CMS finalized its proposal to apply a weight of 70 percent to the clinical process of care domain and 30 percent for patient experience of care. Accordingly, patient care experience is becoming increasingly important to the payments received by a hospital, beyond general public reporting initiatives.

Value-Based Purchasing Incentive Payments

For FY 2013, the VBP payment incentive pool will be funded by reducing participating hospitals' base operating DRG payments for each discharge by 1%. The amount of this reduction will incrementally increase to a 2% reduction by FY 2017.

Hospitals that meet or exceed performance standards under the VBP program will, in turn, receive an increase in their base operating DRG payment amounts. This increase will be determined by multiplying: (1) the base operating DRG payment amount for the discharge by (2) the value-based incentive payment percentage for the hospital for such fiscal year. CMS adopted its proposal to use a "linear exchange function" to calculate the value-based incentive payment percentage, which will distribute VBP dollars to hospitals based on increasing performance. The higher the hospital's achievement or improvement during the performance period, the higher the hospital's value-based incentive payment percentage. Notably, not

all hospitals will earn back the amount of money that they contributed to the VBP incentive pool based on the 1 percent reduction in their DRG payments.

CMS plans to make each hospital's estimated performance scores and value-based incentive payment adjustment amount for FY 2013 available through the QualityNet website at least 60 days prior to October 1, 2012, as required by statute. CMS anticipates that it will notify each hospital of the exact amount of its value-based incentive payment adjustment on November 1, 2012.

While CMS solicited general comments on the structure and procedure of an appropriate appeals process, it has yet to propose such a process. CMS states that future rulemaking will address the process and timing of appeals. That being said, a number of issues are statutorily excluded from administrative or judicial review under the VBP program.

Ober|Kaler's Comments

In the Final Rule, CMS acknowledged that additional quality indicators "topped out," meaning that there is no statistical difference between the 75th percentile and 90th percentile of the specific quality measure. CMS evaluated the new quality indicators for their ability to produce true statistical differentials between hospitals, but CMS has not taken the next step to establish an ongoing evaluation process for topped out measures. A formalized evaluation process would balance CMS's ability to eliminate topped out quality measures as they become a less effective measurement of quality care, while providing the ability to add previously reviewed or new measures as they become quality concerns. Once CMS eliminates a quality measure from the VBP program and/or other quality program, the fear may be that hospitals would focus attention on those quality improvement activities that provide the largest financial return. This lack of attention may cause the eliminated quality measure to receive fewer resources and then again become a quality concern. On-going evaluation also would allow CMS to incentivize cutting edge care and quality improvement consistent with the evolving nature of evidence based medicine.

Another key issue with VBP is the focus not just on the actual care given to the patient in the hospital, but also on the patient experience at the hospital. Hospitals seeking to receive incentive payments under the VBP program should focus

resources toward efforts to make the care experience one that patients would recommend to others. The trend is for hospitals to establish innovative new patient care experience initiatives such as patient follow-up calls post-discharge and new nurse navigator positions that transcend the acute care setting. Perhaps the health care industry will need to move toward hotel-level customer service programs, such as warm blanket services, parking management and meal choice programs.

Provider and health information technology professionals also should pay particular attention to these hospital quality programs, as CMS expands these quality programs to other care settings. A visit to QualityNet shows that quality will be communicated in this type of web-based portal as it expands to other providers such as physician offices and nursing homes. In the future, QualityNet will likely become one stop shopping for quality improvement efforts for Medicare beneficiaries.