CMS Issues Proposed Rule for Implementing Medicare Hospital Value-Based Purchasing Program

On January 7, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for implementing the Medicare Hospital Value-Based Purchasing (VBP) Program. Under this program, hospitals that meet certain performance standards will receive “value-based incentive payments” that would be paid under the Medicare Hospital Inpatient Prospective Payment System (IPPS).

FEDERAL ADMINISTRATIVE AND LEGISLATIVE HEALTH CARE EFFORTS

Linking reimbursement to the quality of health care services provided to Medicare beneficiaries has been a longstanding effort of federal policymakers. Much of the focus has been on hospitals, and the Hospital VBP program is the latest step in this effort.

The Deficit Reduction Act of 2005 (DRA) required CMS to develop a plan to implement a VBP program for hospitals beginning in fiscal year (FY) 2009, and to submit the plan to Congress by August 1, 2007. CMS submitted the DRA-required VBP implementation plan to Congress on November 21, 2007. The report covered various aspects of a hospital VBP program, including measures development and selection, a performance assessment model, options on how to translate a performance score into an incentive payment, infrastructure requirements, public reporting and monitoring VBP impacts.

On November 19, 2008, Senators Max Baucus (D-MT) and Charles Grassley (R-IA), the Chairman and Ranking Member of the Senate Committee on Finance, released draft legislation that would require CMS to implement a hospital VBP program. This legislative language substantially became part of the health care reform law, the Patient Protection and Affordable Care Act (ACA). CMS’s proposed rule implements the hospital VBP program requirements in the ACA.

2 DRA § 5001(b) (Pub. L. No. 109-362).
4 ACA § 3001 (Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act (HCERA) (Pub. L. No. 111-152)). In this article, ACA and HCERA are referred to collectively as the "ACA").
ELEMENTS OF THE HOSPITAL VBP PROGRAM

Section 3001(a) of ACA added a new section 1886(o) to the Social Security Act (SSA), requiring the Secretary to establish a hospital VBP program.\(^5\) VBP incentive payments must be made to a hospital in fiscal years in which the hospital meets established performance standards. Section 1886(o)(1)(B) of the SSA directs the Secretary to begin making value-based incentive payments to hospitals for discharges occurring on or after October 1, 2012. Per SSA section 1886(o)(7), payments will be funded for FY 2013 through a one-percent reduction to FY 2013 base operating diagnosis-related group (DRG) payments for each discharge. The reductions are required to be phased up to two percent in FY 2017 and subsequent years.\(^6\)

Hospitals Subject to the Proposed Hospital VBP Program

The Hospital VBP program applies to hospitals paid pursuant to the IPPS, but excludes 1) hospitals subject to the payment reduction under Section 1886(b)(3)(B)(viii)(I) for failure to report quality data under the Hospital Inpatient Quality Reporting (IQR) Program (formerly known as the Reporting Hospital Quality Data for the Annual Payment Update Program (RHQDAPU)) for such fiscal year; 2) hospitals cited for deficiencies that pose immediate jeopardy to the health and safety of patients during the performance period for the fiscal year; and 3) hospitals for which there is not a minimum number of applicable measures for the performance period for the fiscal year involved, or for which there is not a minimum number of cases for the applicable measures for the performance period for the fiscal year.\(^7\) CMS proposes that the minimum number of applicable measures is four, and the minimum number of applicable cases is 10.

Measures Selection

CMS may only include measures in the Hospital VBP program that have been included on the Hospital Compare website for at least one year prior to the beginning of the performance period and specified under the Hospital IQR program.\(^8\) For the FY 2013 program, CMS is proposing to adopt 18 of the 45 measures for which hospitals must report quality data in FY 2011 for a full annual payment update under the Hospital IQR Program. Seventeen of the proposed measures will be clinical process of care measures. The 18th measure, to address patient experience of care, will be based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The proposed measure set for the Hospital VBP program is listed in the following tables.

\(^5\) ACA § 3001 was amended by § 10335.
\(^7\) SSA § 1886(o)(1)(C), 42 U.S.C. 1395ww(o)(1)(C).
# Proposed FY 2013 Measures

## Clinical Process of Care Measures:

- **Acute Myocardial Infarction:**
  - Aspirin Prescribed at Discharge.
  - Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival.
  - Primary PCI Received Within 90 Minutes of Hospital Arrival.

- **Heart Failure:**
  - Discharge Instructions.
  - Evaluation of LVS Function.
  - ACEI or ARB for LVSD.

- **Pneumonia:**
  - Pneumococcal Vaccination.
  - Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital.
  - Initial Antibiotic Selection for CAP in Immunocompetent Patient.
  - Influenza Vaccination.

- **Healthcare-Associated Infections:**
  - Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
  - Prophylactic Antibiotic Selection for Surgical Patients.
  - Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.
  - Cardiac Surgery Patients with Controlled 6AM Post-Operative Serum Glucose.

- **Surgeries:**
  - Surgery Patients on a Beta Blocker Prior to Arrival That 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 Measures:

- HCAHPS
Outcomes measures would be added in 2014. CMS invites comments on the inclusion of these additional measures for FY 2014:

### Additional Proposed FY 2014 Measures

**Outcomes Measures:**

- **30-Day Mortality Claims-Based Measures:**
  - Mortality-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate.
  - Mortality-30-HF: Heart Failure (HF) 30-Day Mortality Rate.
  - Mortality-30-PN: Pneumonia (PN) 30-Day Mortality Rate.

- **Hospital Acquired Condition Measures:**
  - Foreign Object Retained After Surgery.
  - Air Embolism.
  - Blood Incompatibility.
  - Pressure Ulcer Stages III & IV.
  - Falls and Trauma: (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock).
  - Vascular Catheter-Associated Infections.
  - Catheter-Associated Urinary Tract Infection (UTI).
  - Manifestations of Poor Glycemic Control.

- **AHRQ Patient Safety Indicators, Inpatient Quality Indicators and Composite Measures:**
  - PSI 06—Iatrogenic Pneumothorax, Adult.
  - PSI 11—Post-Operative Respiratory Failure.
  - PSI 12—Post-Operative PE or DVT.
  - PSI 14—Post-Operative Wound Dehiscence.
  - PSI 15—Accidental Puncture or Laceration.
  - IQI 11—Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (With or Without Volume).
  - IQI 19—Hip Fracture Mortality Rate
  - Complication/Patient Safety for Selected Indicators (Composite)
  - Mortality for Selected Medical Conditions (Composite)

In the future, CMS intends to use subregulatory processes instead of notice and comment rulemaking to add new performance measures. Under the proposed process, CMS would add hospital VBP program measures such that the performance period for new measures will begin immediately after they are displayed on Hospital Compare for a period of at least one year.

### Development of Performance Standards

CMS proposes performance standards for each measure that are designed to challenge hospitals to continually improve or maintain high levels of performance.

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9 For these measures, CMS proposes to establish a performance period of July 1, 2011, to December 31, 2012.
Performance Periods

CMS proposes July 1, 2011, through March 31, 2012, as the performance period for the proposed clinical process of care and HCAHPS measures for the FY 2013 Hospital VBP program. To make the FY 2013 payment determination, CMS would compare hospital performance during the performance period to performance during a proposed three-quarter baseline period from July 1, 2009, through March 31, 2010. CMS intends to use full-year performance periods in the future.

Performance Standards

Under the Hospital VBP program, CMS is prohibited from setting a minimum performance standard in determining a hospital performance score. Performance standards would include levels of achievement and improvement, and these standards must be established and announced at least 60 days before the start of the performance period.

CMS proposes to set the achievement performance standard (the achievement threshold) for each proposed measure at the median of hospital performance (50th percentile) during the baseline period. Hospitals would receive achievement points only if they exceed the achievement performance standard. Because the CMS process for validating the proposed baseline period of data is not yet complete, the proposed rule does not provide the precise achievement threshold values for performance standards for each measure. These values will be specified in the final rule.

CMS also proposes to establish an improvement performance standard (the improvement threshold) for each proposed measure to reflect each specific hospital’s performance on the measure during the baseline period. The improvement performance standards are designed to ensure that hospitals will be incentivized to improve.

Calculation of Total Performance Score

To determine total performance score, CMS proposes to use a Three-Domain Performance Scoring Model. The three domains are 1) clinical process of care, 2) patient experience of care and 3) outcomes. Only the first two domains will receive weight in FY 2013, as outcomes measures will not be included in the VBP program until FY 2014.

Scoring the Clinical Process of Care and Outcomes Domains

The proposed methodology for assessing total performance of each hospital will assess both achievement and improvement for each applicable measure. Hospitals would receive points along an achievement range, which is a scale between the achievement threshold and the benchmark. In determining the improvement score, CMS proposes that hospitals would receive points along an improvement range, which would be a scale between the hospital’s baseline period score on the measure and the benchmark.

\[\text{achievement range} \leq \text{achievement threshold} \leq \text{benchmark} \]

\[\text{improvement range} \leq \text{hospital's baseline period score} \leq \text{benchmark} \]

References:


Both benchmarks and achievement thresholds would be established using national data from the baseline period of July 1, 2009, through March 31, 2010. CMS proposes to set the benchmark at the mean of the top decile of hospital scores on the measure during the baseline period.

As noted above, for each applicable measure, a hospital would receive a score based on the higher of its achievement and improvement scores. Points earned for each measure applicable to a hospital would have equal weighting and would be added together to determine the total earned points for the domain.

CMS provides the following example using a pneumonia measure (within the clinical process of care domain) to illustrate the scoring process, using data from 2004 and 2005. In the example, the benchmark calculated for the pneumonia measure is 0.87 (the mean value of the top decile of hospitals in 2004), and the achievement threshold was 0.47 (the performance of the median or the 50th percentile hospital in 2004). In 2005, the example hospital had a performance rate of 0.91 during the performance period for this measure, meaning that 91 percent of applicable patients admitted for pneumonia were assessed and given the pneumococcal vaccine. Because the hospital’s performance rate (0.91) exceeds the benchmark (0.87), the hospital would earn 10 (the maximum) points for achievement. Because the hospital earned the maximum number of points possible for this measure, its improvement score would be irrelevant.

Under the proposed rule, both a hospital’s overall clinical performance score and outcome performance score would be based on all measures that apply to the hospital. CMS proposes that a measure applies to a hospital if, during the performance period, the hospital treats a minimum of 10 cases that meet the technical specifications for reporting the measure. At least four measures within a domain must apply to the hospital in order for the hospital to receive a performance score on that domain. Therefore, the number and type of measures that apply to each hospital will vary, depending on the services the hospital provides. Since some hospitals will not have scores for all measures, and in order to ensure an “apples-to-apples” comparison between hospitals, CMS will normalize a hospital’s clinical process of care and outcome domain scores by converting points earned for each domain to a percentage of the total possible points for that hospital.

**Scoring the Patient Experience of Care Domain**

Scores for the patient experience of care domain (based on HCAHPS performance) would be calculated in a similar manner. CMS is proposing to use the following eight HCAHPS dimensions for the FY 2013 Hospital VBP program: nurse communication; doctor communication; cleanliness and quietness; responsiveness of hospital staff; pain management; communication about medications; discharge information; and overall rating.

CMS proposes to score each of the HCAHPS dimensions using an achievement point range and an improvement point range, with the score on each HCAHPS dimension being the higher of the achievement or improvement score. In addition, the HCAHPS scoring algorithm includes a consistency score. The base HCAHPS score and the consistency score then would be combined into an overall patient experience of care domain performance score.
Calculating the Total Performance Score

To calculate Hospital VBP total performance score for FY 2013, CMS would sum the scores for clinical process of care and patient experience of care domains. The agency proposes to assign weights of 70 percent to clinical process of care and 30 percent to patient experience of care when calculating the total performance score. CMS solicits comments on the appropriate weight to assign to the outcome domain (applicable starting in FY 2014) in future rulemaking.

Calculation of Value-Based Incentive Payment

After calculating each hospital’s total performance scores, CMS proposes to convert these scores into a value-based incentive payment. CMS proposes to adopt a linear exchange function for the purpose of calculating the percentage of the value-based incentive payment earned by each hospital under the Hospital VBP program.

Hospital Notification and Appeals Procedures

CMS proposes to notify hospitals of the one percent reduction to their FY 2013 base operating DRG payments in the FY 2013 IPPS rule. CMS further proposes to inform each hospital of the estimated amount of its value-based incentive payment for FY 2013 discharges through the hospital’s QualityNet accounts at least 60 days prior to October 1, 2012. Each hospital participating in the Hospital VBP program would be required to maintain a QualityNet account. CMS plans to notify each hospital of the exact amount of its value-based incentive payment adjustment for FY 2013 discharges on November 1, 2012. CMS further proposes to give hospitals 30 calendar days to review and submit corrections related to their performance measure scores, condition-specific scores, domain-specific scores and total performance score.

The statute requires CMS to establish an appeals process for the Hospital VBP program. CMS plans to address this requirement in future rulemaking and solicits public comment on the structure of the appeals process and the appropriateness of an agency-level appeals process under which CMS personnel would decide the appeal.

NEXT STEPS

CMS will accept comments on the proposed rule until March 8, 2011. The agency will address the comments in a final rule expected to be released later this year.

The development of the Hospital VBP program regulations should be monitored in light of a number of implications that will likely arise with the implementation of the program. These implications relate to the implementation of VBP programs for other Medicare providers, other ACA provisions linking Medicare reimbursement to health care quality and other quality reporting requirements in the ACA. These implications will likely have a significant impact on Medicare hospital reimbursement and the requirements that hospitals must comply with in order to participate in Medicare.

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