

## HEALTH REFORM IMPACT

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#### More Bang For The Medicare Buck? CMS Proposes Value-Based Purchasing Program For Hospital Inpatient Services

February 17, 2011

On January 13, 2011, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule (the "Proposed Rule")<sup>1</sup> to implement the provision of the Patient Protection and Affordable Care Act ("PPACA")<sup>2</sup> that mandates a value-based purchasing program for hospital inpatient services (the "Program"). In an effort to promote better value, more efficient care, and innovation, the Proposed Rule sets forth a system whereby hospitals are rewarded with incentive-based payments for improvement on specified clinical care and other measures. However, hospitals should be aware that the Program essentially represents a zero-sum game – the bonus payments made to hospitals that demonstrate improvement will be funded by reduction of Medicare diagnosis-related group ("DRG") payment rates to *all* Medicare hospitals starting in fiscal year (FY) 2013.

#### Background

Rewarding providers for submitting data based on quality measures is not a new concept. The 2005 Deficit Reduction Act (the "DRA")<sup>3</sup> established the Hospital Inpatient Quality Reporting Program ("IQR"), the Hospital Outpatient Quality Data Reporting Program, and the Physician Quality Reporting Initiative, which reward hospitals and physicians for simply *submitting* data on certain quality measures. The DRA further required the development and implementation of a value-based purchasing program for payments made under the Medicare program based on the data submitted. Approximately six years later, following extensive research and demonstration projects, and following the further mandate of PPACA, CMS has issued the Proposed Rule in order to develop such a program for inpatient hospital services. The Program takes the idea of mere data submission one step further by structuring a measurement mechanism where

<sup>1</sup> 76 Fed. Reg. 2454 (Jan. 13, 2011).

<sup>2</sup> Pub. L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (Mar. 30, 2010). Section 3001(a) of PPACA adds Section 1886(o) to the Social Security Act, which mandates the Program.

<sup>3</sup> Public Law 109-171.

hospitals may receive increased reimbursement for submitting data reflecting actual quality and efficiency (bear in mind, however, that this increased reimbursement may only offset the DRG payment reductions that are slated to take effect for all Medicare hospitals beginning in FY 2013).

## The Program

The Program applies to so-called “Section (d)” hospitals<sup>4</sup>, which are generally any hospitals reimbursed under the Inpatient Prospective Payment System (“IPPS”). The Proposed Rule provides value-based incentive payments for discharges occurring on or after October 1, 2012 (i.e., the beginning of FY 2013). In order to be eligible for the incentive payments, a hospital must report at least ten (10) cases in each of at least four (4) different clinical process of care measures and have at least 100 Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”) surveys during the defined “performance period.”<sup>5</sup> The first performance period is proposed to begin with the fourth quarter of FY 2011 (July 1, 2011- September 30, 2011) and extend through the first and second quarters of FY 2012 (October 1, 2011-March 31, 2012), with payment adjustments reflected beginning in October of 2012. One exception to the foregoing is that the initial performance period for three 30-day mortality measures that will be adopted for FY 2014 will be 18 months, from July 1, 2011 through December 31, 2012.

The Proposed Rule creates two domains of performance measures. First, there are 17 clinical process of care measures, which represent a subset of the 45 measures adopted under the Hospital IQR program, and second, there are eight (8) HCAHPS measures, creating a total of 25 measures that are currently displayed on *Hospital Compare*.

CMS proposes to implement additional measures in the future without the necessity of rulemaking and comment, i.e., the performance period for the additional measures will automatically begin after they are displayed on the *Hospital Compare* Web site for a period of at least one year. CMS has also proposed outcome-based measures for the FY 2014 Program and may ultimately score hospitals on a three-domain system, rather than two. The three domains will include clinical process of care, HCAHPS, and outcome measures.

## Payment Calculations for the Clinical Process of Care Domain

The scoring methodology compares the hospital's current performance period score with a baseline score. The hospital's baseline period is defined as the hospital's performance from July 1, 2009 to March 31, 2010 for most of the measures (the exception being the three 30-day mortality measures that begin in FY 2014, which are measured from July 1, 2008 through December 31, 2009). The hospital essentially sets its own baseline score, based on past performance.

The methodology measures a hospital's “improvement” compared to its baseline and a hospital's “achievement” by comparing the hospital's current performance period to all hospitals'

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<sup>4</sup> The Value-Based Purchasing Program is applicable to all hospitals other than psychiatric hospitals, rehabilitation hospitals, prospective payment system- (PPS) exempt children's hospitals, PPS-exempt cancer hospitals, critical access hospitals, long-term acute care hospitals and hospitals located in Puerto Rico or other territories. 42 U.S.C. 1395 (d)(1)(B).

<sup>5</sup> Hospitals that are subject to payment reductions under the Hospital IQR and hospitals cited for deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients are ineligible for the incentive payments.

baseline performance. Before a hospital's improvement score and achievement score are calculated, the hospital will receive a "benchmark" in addition to its baseline score. The hospital's benchmark for a particular measure is the mean score achieved by the top-performing decile of all hospitals on that measure. There is also an "achievement threshold," or floor, for use in determining the hospital's "achievement" for each measure, defined as the national median score for the particular measure.

### *Improvement Score*

If a hospital scores greater than the benchmark, a total of 10 improvement points will be awarded. If a hospital scores equal to or less than the baseline (no improvement), then zero (0) improvement points are awarded. If a hospital scores somewhere in between the baseline and benchmark, the hospital will receive between zero (0) and nine (9) points, based on "a unique improvement range for each measure established for each hospital that defines the distance between the hospital's baseline period and the national benchmark."<sup>6</sup> CMS sets forth a mathematical formula used to calculate this score. Keep in mind that a hospital's performance during the performance period must be greater than the baseline in order to receive any improvement points at all.

### *Achievement Score*

A hospital earns achievement points by comparing the hospital's individual scores with all hospitals' scores from the baseline period. Similar to the improvement scores, if a hospital scores greater than or equal to the benchmark, the hospital receives 10 points for achievement. If the hospital scores equal to or less than the achievement threshold, the hospital receives zero (0) points. If a hospital scores greater than the achievement threshold but lower than the benchmark, a score of one to nine (1-9) will be given, again based on a mathematical formula set forth by CMS in the Proposed Rule.<sup>7</sup> Note that because the achievement score is based upon a comparison with other hospitals, the achievement threshold is used as the "floor" rather than the hospital's individual baseline.

### *Total Clinical Process of Care Score*

The total clinical process of care performance score for a hospital for each measure is the higher of the hospital's achievement score or improvement score on that measure. Note that the clinical process of care domain accounts for 70% of a hospital's grand total performance score.

## **Payment calculations for the HCAHPS Domain**

The HCAHPS domain, containing eight (8) measures, accounts for the remaining 30% of the hospital's grand total performance score. The greater of the improvement or achievement score from each HCAHPS measure, plus a consistency score, equals the total HCAHPS score. Each measure will be scored using the same methodology as the clinical process of care

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<sup>6</sup> 76 Fed. Reg. at 2467.

<sup>7</sup> To ensure comparability between hospitals with different numbers of applicable measures, CMS will mathematically normalize the domain scores for clinical process of care.

measures. Consistency points, which are unique to the HCAHPS domain, seek to measure whether the hospitals are consistently meeting the achievement thresholds across the eight proposed dimensions. A hospital may earn a consistency point from zero (0) to 20 based on how many of its dimensions meet or exceed the achievement threshold.

## **The Grand Total**

As mentioned above, the clinical process of care score will be weighted to reflect 70% of the total score and the HCAHPS score will be weighted to reflect the remaining 30%. If additional domains, such as outcomes measures, are added in the future, CMS will readjust the domain weighting in future rulemaking.

CMS proposes to adopt a “linear exchange function” for the purpose of translating the total performance scores earned by a particular hospital into its value-based incentive payments. According to CMS, the linear exchange function is the “simplest and most straightforward” of all of the mathematical exchange functions that were considered by CMS and provides all hospitals the same marginal incentive to continually improve. Hospitals can expect to receive individual notification of incentive payments by November 1, 2012. Scores will be posted on *Hospital Compare*, and hospitals will have 30 days to review their scores and submit corrections. Note, however, that under the Proposed Rule, neither the incentive-based payment determinations nor the measures used by CMS nor the methodology used to calculate the payments is subject to appeal or review.

## **Expressed Concerns and Conclusion**

Although many applaud the Program’s intention to promote improvement and efficiency in healthcare delivery, we can expect to see many comments and questions, hopefully coupled with more clarification, when the final rule is published. In a recent CMS Open Door Forum, industry experts voiced a variety of concerns, including concerns over the fact that CMS proposes to add future measures through the “sub-regulatory process” instead of the formal regulatory process, concerns over the Program’s subjective aspects (particularly stemming from the HCAHPS measures), and concerns over the unadjusted application of the Program to all types of hospitals - big/small, urban/rural, and those with inherently severe patients vs. those with a healthier patient mix. Many hospitals are also curious as to the manner in which the value-based incentive payment will be made, e.g., through a rate adjustment for the hospitals earning the payment or through other means, and whether this issue will be clarified in the next final IPPS payment update.

If you have questions regarding the information in this alert, please contact any of the attorneys in our Healthcare Practice Group listed below.

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