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Quality Marches On: The Final Hospital Value-Based Purchasing Rule And The New Partnership For Patients Program

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The Centers for Medicare & Medicaid Services ("CMS") recently issued the final value-based purchasing rule for hospital inpatient services (the "Final Rule").[1] With a few exceptions, the Final Rule is essentially unchanged from the original proposed version of the rule that we discussed in a previous issue of *Health Reform IMPACT*.[2] As our readers may recall, the value-based purchasing program, which ties part of a hospital's Medicare reimbursement to achieving certain quality standards, is a mandate of the Patient Protection and Affordable Care Act ("PPACA").[3]

Under the Final Rule, CMS will distribute an estimated $850 million to Medicare participating hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. A hospital's "score", which determines the size of the hospital's incentive payment, will be weighted as follows for the first year of program: 30 percent will be based on patient experience scores using the Hospital Consumer Assessment of Healthcare Providers and Systems survey ("HCAHPS"); and 70 percent will be based on 12 clinical process-of-care measures. The *proposed* rule had included 17 process-of-care measures rather than 12, but five were removed from the *final* rule because CMS believed the majority of hospitals had already "topped out", or reached a high level of performance, on those metrics. Some of the measures are intended to assess, among other things, whether hospitals:

- Ensure that patients who may have had a heart attack receive care within 90 minutes;
- Provide care within a 24-hour window to surgery patients to prevent blood clots; and
- Communicate discharge instructions to heart failure patients.

Hospitals' scores may be based on their levels of *achievement* of quality measures relative to other hospitals, or their levels of *improvement* in comparison to their own prior data.[4] To determine a baseline for each hospital for the first year of the program, CMS will analyze previously reported hospital data

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[1] 76 Fed. Reg. 26490 (May 6, 2011).

[2] Read "More Bang For The Medicare Buck? CMS Proposes Value-Based Purchasing Program For Hospital Inpatient Services."

[3] 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.

[4] The scoring details are set out in detail in the Final Rule.

from July 1, 2009 through March 31, 2010. CMS will compare this baseline against data that will be collected during an initial performance period running from July 1, 2011 to March 31, 2012. On the basis of this data, CMS will begin making incentive payments to hospitals for discharges occurring on or after October 1, 2012 (i.e. the beginning of fiscal year 2013).

In the future, CMS plans to add measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. Measures that have reached very high compliance scores will likely be replaced. Beginning in 2014, CMS will introduce three mortality outcome measures, eight hospital-acquired condition measures, and two Agency for Healthcare Research and Quality ("AHRQ") composite measures. In one of the few changes from the proposed rule, CMS decided *not* to implement a plan to adopt and retire measures using a sub-regulatory process that would forgo notice and comment.

To make the value-based program budget-neutral, CMS will implement an across-the-board 1 percent reduction in hospitals' base operating diagnosis-related group ("DRG") payments, starting October 1, 2012, and will use the projected $850 million in savings to fund the value-based incentive payments. The 1% reduction will gradually increase each year, topping off at 2 percent by fiscal year 2017 and beyond, meaning that an increasing proportion of hospital payments will be tied to quality measures.

Partnership for Patients Program Launched

The hospital value-based purchasing rule reinforces the goals of another program called the "Partnership for Patients" that was recently launched by the U.S. Department of Health and Human Services ("HHS"). The Partnership for Patients program is a new public-private partnership that is designed to improve the quality, safety and affordability of healthcare. The purpose of the program is to decrease hospital-acquired conditions and prevent complications during a transition from one care setting to another (which would in turn prevent hospital readmissions). HHS believes that the program has the potential over the next three years to save 60,000 lives and save up to $35 billion in U.S. healthcare costs, including up to $10 billion for Medicare.

The program uses up to $1 billion of federal funding that was made available under PPACA. This $1 billion is divided between two initiatives. First, $500 million of the funding will be used by the CMS Innovation Center to support new demonstrations related to reducing hospital-acquired conditions. The initial focus of the Innovation Center will be on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated, including preventing adverse drug reactions, pressure ulcers, childbirth complications and surgical site infections. The Innovation Center will help hospitals adopt evidence-based care improvements to reduce patient injuries and develop approaches to spreading and sharing strategies among public and private partners. The other $500 million of the funding is available through the Community-Based Care Transitions Program, under which community-based organizations and eligible hospitals partner together to help patients safely transition between settings of care. Eligible organizations and hospitals that partner with them can now begin submitting applications for this funding.

In addition, hospitals, employers, health plans, physicians, nurses and state governments can voluntarily "pledge their commitment" to the Partnership for Patients program online. Note that the voluntary pledge is separate from the funding component of the program discussed above. At this point, it is not clear that any specific rights or obligations are associated with making the pledge, other than an aspiration to the program's quality improvement goals.[5]

An HHS fact sheet announcing the Partnership for Patients program cited a 1999 study by the Institute of Medicine titled "To Err is Human" which estimated that as many as 98,000 Americans die each year from preventable medical errors, and a 2011 study in the *Health Affairs* journal finding that about one in three

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[5] Additional details about the program can be found on the HHS website.

patients admitted into a hospital suffer a medical error or adverse event. HHS intends for the Partnerships for Patients program, along with the hospital value-based purchasing rule and other initiatives, to significantly improve quality, reduce adverse outcomes and ultimately reduce U.S. healthcare costs.

If you have any questions about this issue of *Health Reform IMPACT*, please contact any of the attorneys in our Healthcare Practice Group listed below.

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Bass, Berry & Sims Healthcare Attorneys

Philip F. Berg (615) 742-7908 pberg@bassberry.com	**Krista T. Cooper** (615) 742-7734 kcooper@bassberry.com	**Meredith Edwards** (615) 742-7823 medwards@bassberry.com	**Mary Beth Fortugno** (615) 742-7739 mfortugno@bassberry.com
Valere Fulwider (615) 742-7822 vfulwider@bassberry.com	**Lauren Gaffney** (615) 742-7824 lgaffney@bassberry.com	**Pooneh Ghiassi** (615) 742-7782 pghiassi@bassberry.com	**Anna Grizzle** (615) 742-7732 agrizzle@bassberry.com
Elisa E. Harris (615) 742-6553 eharris@bassberry.com	**Angela Humphreys** (615) 742-7852 ahumphreys@bassberry.com	**J. James Jenkins, Jr., Chair** (615) 742-6236 jjenkins@bassberry.com	**Seth A. Killingbeck** (615) 742-7707 skillingbeck@bassberry.com
Daniel R. Kuninsky (615) 742-7837 dkuninksky@bassberry.com	**Claire F. Miley** (615) 742-7847 cmiley@bassberry.com	**T. Scott Noonan** (615) 742-6273 snoonan@bassberry.com	**Shannon Pinkston** (615) 742-7727 spinkston@bassberry.com
Cynthia Y. Reisz (615) 742-6283 creisz@bassberry.com	**Brian D. Roark** (615) 742-7753 broark@bassberry.com	**Catherine J.B. Sloan** (615) 742-7789 csloan@bassberry.com	**Danielle M. Sloane** (615) 742-7763 dsloane@bassberry.com
Nesrin Garan Tift (615) 742-7903 ntift@bassberry.com	**Leigh Walton** (615) 742-6201 lwalton@bassberry.com	**Elizabeth S. Warren** (615) 742-7719 ewarren@bassberry.com	**Douglas M. Wolford** (615) 742-7917 dwolford@bassberry.com

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