American Hospital Association

Quality Advisory

April 12, 2007

CMS Issues Options Paper on Medicare Hospital Value-Based Purchasing

AT A GLANCE

The Issue:

On March 22, the Centers for Medicare & Medicaid Services (CMS) released an Options Paper on its value-based purchasing (VBP) initiative more closely linking hospital payment to performance. This is the last major step before CMS sends Congress a proposal for implementing Medicare VBP. The Medicare Payment Advisory Commission is crafting its own recommendations, and the two documents will provide the foundation for congressional deliberations on whether Medicare should move forward with a VBP strategy.

This advisory summarizes the VBP methodology outlined by CMS and gives instructions for hospitals to provide CMS with feedback on the plan. It also includes a comprehensive discussion of the components of the plan, noting issues for which CMS explicitly is seeking input.

What You Can Do:

The VBP approach only applies to hospitals paid under the Medicare inpatient prospective payment system (PPS); critical access hospitals and other hospital types are excluded. Please share this advisory with your quality, finance and operations leaders, as well as your medical staff leadership. CMS will accept written comments on the Options Paper until April 19th at 5 p.m. ET. Comments may be e-mailed to cmshospitalVBP@cms.hhs.gov, faxed to 410-786-0330, or mailed to:

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Further Questions:

Contact Nancy Foster, AHA vice president of quality and patient safety policy, at (202) 626-2337 or nfoster@aha.org.

AHA's Quality Advisories are produced whenever there are significant developments that affect the job you do in your community. A four-page, in-depth examination of this issue follows.

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BACKGROUND

The Deficit Reduction Act of 2005 (DRA) required the Centers for Medicare & Medicaid Services (CMS) to develop an approach to value-based purchasing (VBP) for Medicare hospital services and one that could be put in place as early as fiscal year (FY) 2009. No change can occur, however, without further Congressional action. The VBP approach only applies to hospitals paid under the Medicare inpatient prospective payment system (PPS); critical access hospitals and other hospital types are excluded. CMS recently released an Options Paper, available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf, outlining its current approach to implementing the VBP program.

AS IT STANDS

While no change can occur without further congressional action, the VBP program designed by CMS would begin in FY 2009 (October 1, 2008). CMS' proposal builds on the existing framework of the current pay-for-reporting program. It is anticipated that the VBP program also will include hospital outpatient measures, as required by the *Tax Relief and Health Care Act of 2006*.

Scoring Hospital Performance

Hospitals would be required to submit data on all quality measures applicable to their patient populations and service mix to qualify for the VBP program incentive payment. On an annual basis, CMS would assess each hospital's performance and assign the hospital a performance rate for each measure. To calculate a performance rate for a measure, CMS would divide the number of applicable patients who received the care specified in the measure by the total number of applicable patients. For example, if 91 out of 100 applicable patients received the care specified in the quality measure, the hospital's performance rate for that measure would be 0.91.

The VBP program would reward hospitals that *improve* their quality performance, as well as those that *achieve high levels* of performance. For each measure, hospitals would receive an attainment score that compares their performance rate to the median performance rate and a CMS-designated benchmark rate for exemplary performance. Each hospital would receive a second score based on the improvement in its performance rate for that measure compared to the previous year's rate. CMS would use the higher of a hospital's attainment or improvement score to determine the hospital's final score for each measure. A hospital can earn a maximum of 10 points for each measure.

A hospital's overall VBP performance score would be calculated as follows:

$$\text{Total VBP performance score} = \frac{\text{sum of the total number of points earned for all measures reported}}{\text{total number of points possible (the number of measures reported x 10 points)}}$$

Incentive Payments

Incentive payments would be based on hospitals' scores. CMS would first set a *benchmark* performance score – such as 85 percent or 90 percent – above which hospitals would receive the full VBP incentive amount. Hospitals below the performance benchmark would receive a portion of the VBP incentive amount. CMS may set a minimum performance score threshold – such as 10 percent – below which hospitals would not receive any VBP incentive payment.

The incentive payment amount would be a percentage of the diagnosis-related group (DRG) payment, not a percentage of the annual payment update, as is done under the current pay-for-reporting program. The actual amount of the incentive payment is as yet undetermined. CMS specifically requests comments from stakeholders on which parts of the inpatient PPS payment should be subject to the incentive. The incentive payments could apply to base DRG payments with geographic adjustments only or to any of the following:

- Capital costs;
- Disproportionate share hospital payments;
- Indirect medical education payments; or
- Outlier payments.

In addition, CMS is seeking comment on whether any remaining incentive payments resulting from the likely event that not all hospitals earn their full VBP incentive payment should be distributed:

- To all hospitals based on their VBP performance scores; or
- To top performers only, potentially with a cap so that no single hospital receives an unusually large payment.

Reporting Measures

The reporting measures for the VBP program would be developed from the measures already established for public reporting, although not all measures currently required for reporting may be incorporated into the set of measures used for incentive payments. For example, CMS proposes that the measure for beta blocker at arrival for acute myocardial infarction initially be excluded from the VBP payment incentive measure set because the clinical evidence base for the measure appears to be changing.

When new measures are developed, CMS proposes to introduce them into the VBP program using a staged approach. There would be a preliminary data submission period during which hospitals would be required to submit data to CMS and become familiar with the specifications and data submission requirements of the new measures. Next, the new measures would be publicly reported for a period of time, but not included in the measure set used for the payment incentive. Finally, the measures would be included in the set for the payment incentive, if appropriate.

Transition Timeline

CMS provides several proposed timelines for transitioning to the VBP program. In one proposal, CMS outlines a phased approach such that in year one, FY 2009, 100 percent of the VBP incentive payment would be based on measure reporting. In FY 2010, 50 percent of the payment would be based on reporting and 50 percent of the payment would be based on performance. Beginning in FY 2011, 100 percent of the payment would be based on performance. Another approach identified by CMS would base 100 percent of the VBP program payment on performance beginning in FY 2009.

Data Submission Process Changes

CMS proposes a number of changes to the data infrastructure to support the VBP program. First, CMS would compress the time period for hospital data submission from the current 135 days to 60 days. CMS also would allow hospitals or their vendors to resubmit their data for up to 30 days after the close of the data submission period, if an error is discovered during the submission process. CMS proposes revising the data validation process to review more charts from a smaller number of hospitals, approximately 800, selected each year on both a targeted and random basis.

Participation by Low-volume Hospitals

CMS is exploring different approaches to enable participation by hospitals that have low numbers of cases and/or applicable measures. The agency proposes that hospitals participate in the VBP program if they have a minimum number of cases and measures as follows:

- A minimum of 10 cases per measure; AND
- A minimum of five reported measures, OR at least 50 cases associated with fewer than five reported measures.

CMS specifically requests stakeholders comment on this proposal or other alternatives to include low-volume hospitals in the VBP program.

NEXT STEPS

The AHA is encouraged that CMS has accepted several of our earlier comments, including the proposal that hospitals be rewarded for improvement in performance in addition to attainment of a level of excellence, and that the validation process could be improved if a smaller, randomly selected number of hospitals be audited each year under the new program.

In our comments on the Options Paper, we will suggest that CMS carefully consider how to design the program in a way that builds predictability into the system for hospitals regarding the measures on which they will be reporting, the time frame and infrastructure used for data submission, and the structure of the performance measurement process and the financial incentives. We also will recommend that CMS phase in the VBP program over several years.

In your own comments, we encourage you to advise CMS to:

1) Proceed incrementally and judiciously in implementing such a complex program;
2) Build predictability and transparency into the design of the program; and
3) Work with other members of the Hospital Quality Alliance, including the AHA, to develop an implementation plan that provides the infrastructure to collect, verify, and display the data while minimizing the administrative burden.

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