CMS Issues Final Hospital Value-Based Purchasing Rules

On April 29, 2011, the Centers for Medicare & Medicaid Services (CMS) released its final rule to implement a hospital value-based purchasing (VBP) program as mandated by the *Affordable Care Act* (ACA) of 2010. The program, which applies to payments for hospital discharges occurring on or after October 1, 2012, is designed to reward hospitals that score well on certain quality care measures with higher payments. Although CMS received over 300 comments to the proposed rule, the final rule is largely unchanged. The text of the final rule is available here.

The VBP program builds on quality measures already reported by hospitals under the Medicare Hospital Inpatient Quality Reporting Program (Hospital IQR Program), as well as borrowing heavily from a 2007 CMS report entitled "Plan to Implement a Medicare Hospital Value-Based Purchasing Program." Pursuant to the ACA, VBP program incentive payments will be funded by reducing hospitals' base operating diagnosis related group (DRG) payments by 1% in federal fiscal year (FY) 2013, rising to 2% by FY 2017, all of which will be paid out as incentives. The Hospital IQR Program will operate in parallel to the VBP program, and a hospital must continue to participate in the reporting program to avoid payment reductions under that program.

Performance Measures

For FY 2013, CMS will implement quality measures consistent with the ACA's mandate to address acute myocardial infarction, heart failure, pneumonia, surgical care activities, healthcare-associated infections, and patient perceptions of care. Performance measures under the final rule will be broken into three categories: clinical process of care, patient experience, and outcome measures.

CMS will initially use twelve of the seventeen measures that it had originally proposed to derive from the Hospital IQR Program to measure clinical processes of care. Most of the remaining five measures were removed as "not meaningful" due to widespread achievement (so called "topped-out"). In future rules, CMS will continue to evaluate data and remove measures as they become topped-out. Also effective FY 2013, CMS will use eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to measure patient experience.

Thereafter, beginning with FY 2014, CMS will expand these measures of clinical process of care and patient experience to include eight Hospital Acquired Condition measures and two composite AHRQ Patient Safety Indicator and Inpatient Quality Indicator measures (of the nine proposed). Also for FY 2014, CMS will implement patient outcomes as a third category and use three risk-standardized mortality measures.

CMS had originally proposed creating a subregulatory process allowing it the flexibility to add new measures without public comment, but due to negative comments CMS ultimately rejected this process.

Calculating Performance

Hospitals are eligible to receive incentive payments not only for achieving specified quality benchmarks, but also for improving their performance as compared to a baseline period. To generate hospital performance scores, CMS will use a model with three separate scoring domains (the Three-Domain Performance Scoring Model): clinical process of care, patient experience, and, beginning in FY 2014, outcome measures.

- **Clinical process of care scores**. Clinical process of care scores are the higher of an achievement score and an improvement score. To earn points for achievement, a hospital must perform at least as well as half of all hospitals on a given measure during the performance period. To earn improvement points, a hospital must exceed its own baseline period performance.

- **Patient experience of care scores**. Patient experience of care scores are a combination of (1) the higher of an achievement score and an improvement score calculated in a manner similar to the clinical process of care score, and (2) a consistency score based on the strength of a hospital's lowest component score among the patient experience measures.

- **Outcome scores**. Outcome scores will be implemented beginning in FY 2014 following the same methodology as clinical process of care scores, and will initially be based on three measures of mortality (but using a twelve-month performance period beginning July 1, 2011, and a twelve-month baseline period beginning July 1, 2009).

Performance Period. The measurement period for clinical process of care and patient experience performance for FY 2013 comprises the three quarters beginning July 1, 2011. For later fiscal years, CMS anticipates using data from a full twelve months as the performance period for clinical process of care and patient experience measures, but has left that change to a future proposal. The baseline period against which performance improvement will be measured for FY 2013 payment purposes is July 1, 2009 to March 31, 2010, and CMS has now published the various achievement levels based on data from this period. With respect to the eight finalized HAC measures and the two finalized AHRQ measures that are due to take effect in FY 2014, the performance period will begin on March 3, 2012.

Total Performance Score. For FY 2013 CMS will calculate each hospital's total performance score by weighting its clinical process of care score by 70% and its patient experience of care score by 30%. CMS plans to make each hospital's estimated performance scores and incentive payments available to it 60 days prior to October 1, 2012. Actual scores and payment amounts will not be available until November 1, 2012. Each hospital's total performance, domain-specific, and condition-specific scores will be made publicly available on the Hospital Compare website, pursuant to the ACA.

If you have questions about this final rule or other aspects of value-based purchasing, please contact the Ropes & Gray attorney who normally advises you.