In a report to Congress on the national strategy for quality improvement in healthcare, the Department of Health and Human Services (HHS) noted that the Centers for Disease Control and Prevention estimates that “at least 1.7 million healthcare-associated infections occur each year and lead to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year—and the cost of treating patients who are harmed by these events is estimated to be as high as $5 billion annually.” With the ever-looming budget crisis, there is little doubt that Congress and HHS want to find ways to improve the quality of care while reducing costs. As part of its efforts to move from a passive payor for care to an active purchaser of higher quality, more efficient healthcare, the Centers for Medicare and Medicaid Services (CMS) has instituted and has plans to institute a number of measures, including various value based purchasing (VBP) programs.

Value-Based Purchasing for Hospitals

Similar to other VBP programs mandated by the Affordable Care Act (ACA), the goal of the hospital inpatient VBP program (Hospital VBP Program or Program) is to reward hospitals financially for providing higher quality care. The Program aims to accomplish this by withholding 1% (growing to 2% over five years) of base operating diagnosis-related group (DRG) payments from hospitals. The amounts withheld will be placed into a pool and CMS will distribute the funds to hospitals based on quality measures. The amount of a hospital’s payment will be directly proportional to the hospital’s quality score. The Hospital VBP Program is designed to be budget neutral so that the government’s total payments will be the same as they would have been without the Program. However, there will be hospital winners and losers. Some hospitals will earn back more than the amount withheld, but some will earn back far less.

The Hospital VBP Program was mandated by Section 3001(a) of the ACA and became Section 1886(o) of the Social Security Act. CMS published a proposed rule for the Program in January 2011, published the final rule on May 6, 2011, and addressed matters related to the Program in other rulings along the way.

Program Criteria

Hospitals that receive reimbursement through the inpatient prospective payment system (IPPS) are included in the program if they report to CMS on at least four of the 12 Processes of Care measures (with at least ten cases per measure) and have at least 100 completed Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. The ACA requires a value-based purchasing program for hospitals with lower volumes, but it has not been announced yet. The Program is not optional if a hospital meets the inclusion criteria. The Program includes hospitals in all 50 states and the District of Columbia, even though Maryland hospitals do not receive reimbursement through IPPS. The Hospital VBP Program excludes certain hospitals from participating including hospitals that have received an immediate jeopardy deficiency during the performance period and hospitals that fail to satisfy CMS’ inpatient reporting requirements and are subject to payment reductions. Excluding the latter category prevents CMS from double-dipping because hospitals that are not satisfying reporting requirements are already assessed a 2% penalty.

How the Hospital VBP Program Measures Quality

The foundation of any pay-for-performance program must be a fair and effective system for measuring quality. The ACA requires CMS to establish standards to evaluate the perfor-
mance of hospitals during each fiscal year (FY) of the Hospital VBP Program. In considering and adopting the measures, CMS must take into account practical experience with the measures, historical performance standards, improvement rates, and opportunity for continued performance. The Hospital VBP Program aims to reward performance and improvement, placing considerable emphasis on the patients’ experience.

For FY 2013 and FY 2014 of the Hospital VBP Program, CMS has developed three aspects of care, called domains, to measure hospital performance. These domains include Process of Care, Experience of Care, and Mortality (Outcomes). For each domain, CMS has selected specific measures. For each measure, CMS has set a performance standard and benchmark against which a hospital’s performance will be measured. To determine a hospital’s score on each individual measure, both the hospital’s achievement and its improvement will be calculated, and the highest score will be used. This reflects the Hospital VBP Program’s intent not only to reward the highest quality, but also to encourage hospitals to improve care. Once the scores on the various measures are combined to create domain scores, the domain scores are weighted and combined to create a single score, called a Total Performance Score.

For FY 2013, CMS has adopted 12 Process of Care measures that focus on acute myocardial infarction, heart failure, pneumonia, healthcare-associated infections, and surgical care. CMS originally proposed 17 Process of Care measures, but it ultimately determined not to adopt five of them. CMS determined that three of the 17 were “topped out” and two others were being retired from the Hospital Inpatient Quality Reporting Program. Examples of the adopted measures include “Percent of Heart Attack Patients Given PCI Within 90 Minutes of Arrival” and “Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.” The complete list of Process of Care measures, plus a description of the Experience of Care measures can be found at www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011b.html.

A hospital’s score for the Process of Care domain is based on the measures applicable to the hospital. For example, if a hospital does not have enough heart attack patients to meet the reporting threshold (at least ten cases per measure), the hospital’s score will not include measures related to heart attack. The hospital reportable measures are normalized in the score calculation so that a hospital is not penalized for not reporting on all measures.

Patient Experience of Care measures are based on eight different dimensions of the HCAHPS surveys. The HCAHPS surveys query a random sample of patients regarding their opinions on their hospital care and evaluate communication with physicians and nurses, responsiveness of hospital staff, pain management, communication about medications, discharge information, and cleanliness and quietness of the hospital environment. A hospital’s score for Experience of Care also takes into account such hospital’s consistency on patient satisfaction measures. If a hospital scores below the 50th percentile on any patient satisfaction measure, it will lose points for lack of consistency.

The Hospital VBP Program scoring process awards points for performance relative to achievement thresholds and national benchmarks. CMS has set achievement thresholds and benchmarks for all Process of Care and Experience of Care thresholds for FY 2013, as well as Outcome (Mortality) Measures for FY 2014.

Once a score for each of the domains is determined, weighting is applied and the scores are combined to calculate a Total Performance Score. CMS uses the Total Performance Score to calculate a hospital’s value-based incentive payment. A hospital’s score and resulting incentive payment for a given fiscal year cannot impact a later year’s score calculation or incentive payment. For FY 2013, the score for the Process of Care domain is weighted at 70% and the Experience of Care domain is weighted at 30%. Some hospitals may be concerned that CMS places too much emphasis on patient Experience of Care, particularly urban hospitals with diverse patient bases. However, other hospitals may see this as an opportunity to improve their score simply by focusing on providing the patient with a better experience.

The VBP incentive payment for FY 2014 will be based on the FY 2013 measures, unless the measure becomes “topped out,” plus an additional Process of Care measure (SCIP-Inf-9) and Outcome (Mortality) measures. The Outcome (Mortality) measures assess all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack, heart
failure, or pneumonia. CMS defines all-cause mortality as death from any cause within 30 days after the admission date, regardless of whether the patient died in the hospital or after discharge. To account for the addition of Outcome (Mortality) measures, CMS shifted the domain weighting for FY 2014 to Process of Care at 45%, Experience of Care at 30%, and Outcomes (Mortality) at 25%. It is interesting to note that the weighting of Experience of Care remains the same while CMS reduced the weighting of Process of Care measures to make room for Outcomes (Mortality) measures. It appears that CMS believes that better patient experiences will result in better care and less cost.

CMS had adopted two Agency for Healthcare Research and Quality (AHRQ) composite measures, eight Hospital Acquired Condition measures, and a Spend Per Beneficiary measure that it incorporated into a new Efficiency Domain, but in a surprise decision, CMS suspended the effective dates of these measures because data will not have been made publicly available on the Hospital Compare website for at least one year prior to the performance period start date. CMS intends to adopt these measures in future years of the Hospital VBP Program.

Timeframes for Measuring Quality
While CMS calculates a hospital’s reduction to base operating DRG and its VBP payment on a fiscal year basis, a hospital’s performance is scored during a different time period established by CMS and called the “performance period.” CMS establishes the performance periods for each domain to be used in calculating VBP incentive payments. CMS uses a hospital’s reported performance during the performance period to score a hospital on each measure. Because CMS scores both achievement and improvement, CMS also establishes baseline periods for assessing hospitals’ improvement.

For FY 2013, the performance period for the Process of Care and Experience of Care domains is July 1, 2009 through March 31, 2010. Note that these timeframes, established by the final rule, are different from the proposed rule.

For FY 2014, the performance period for the Process of Care and Experience of Care domains is April 1, 2012 through December 31, 2012 while the baseline period for the same domains is April 1, 2010 through December 31, 2010. The performance period for FY 2014 for the Outcome (Mortality) domain is July 1, 2011 through June 30, 2012 while the baseline period is July 1, 2009 through June 30, 2010. Note that despite not affecting a hospital’s VBP incentive payment until FY 2014, the performance period for the Outcome (Mortality) domain is already well underway.

Hospital VBP Program Funding
The Hospital VBP Program is funded by CMS reducing the base operating DRG payment amount to hospitals for each discharge. The amount CMS will withhold begins at 1% for FY 2013 and increases 0.25% each year until the percentage is 2% in FY 2017. Importantly, portions of Medicare payments for outliers, disproportionate share, low volume, and indirect medical education will not be affected. The Hospital VBP Program is designed to be budget neutral; thus, the amount available for VBP incentive payments in a fiscal year will be equal to the total amount withheld from payments to hospitals. CMS will begin withholding the applicable percentage at the beginning of FY 2013 on October 1, 2012.

Considerations for Hospital Executives
Hospital executives should keep in mind that performing very well in a single domain does not guarantee a high VBP incentive payment. To maximize payments, hospitals should work towards scores above the achievement thresholds in all domains. Hospitals should be aware that FY 2013’s performance period is nearly over. However, with some effort, hospitals have time for one final push to improve scores on measures in both the Process of Care and Experience of Care domains.

While the time remaining in the performance period for FY 2013 may be critical to improving a hospital’s first VBP incentive payment, hospitals also must be planning and implementing strategies now to address the measures that will be added to the Program in FY 2014. The addition of the Outcome (Mortality) measures in FY 2014 will likely alter the landscape dramatically and hospitals that receive a high VBP payment for FY 2013 will need to carefully evaluate how the Outcome (Mortality) measures will affect their payment in FY 2014.

Hospitals should monitor CMS announcements regarding the Hospital VBP Program on an ongoing basis so they can begin developing strategies to address the various quality measures as soon as they are announced. Further, hospitals need a robust mechanism in place to monitor and improve their scores in the various quality measures.

Regardless of the position in which a hospital currently finds itself, there is an opportunity to improve and maximize
the VBP incentive payment. Lower performing hospitals should focus on improving their lowest scores in both Process of Care and Experience of Care measures. While it is true that increasing a hospital's payment from improvement gets more difficult the higher the performance score, high performing hospitals should identify key measures that provide the greatest opportunity to increase the hospital's VBP incentive payment, and begin focusing on measures that will be used in future fiscal years.

Value-Based Purchasing for Post-Acute Care

The federal government’s long-range healthcare goal to increase access to higher-quality preventative and coordinated care for Medicare beneficiaries while reducing overall healthcare costs does not stop at the hospital door. It extends to other healthcare providers as well. One measure CMS will use to reduce costs is to penalize hospitals and other providers for hospital readmissions. Post-acute care (PAC) providers, and especially skilled nursing facilities (SNFs), are one source for hospital readmissions. Therefore, the ACA contemplates the development and implementation of a SNF VBP Program over the next few years. This program makes the PAC provider a center-stage player as the aging population (and thus, Medicare beneficiaries) increases exponentially. PAC providers will need to successfully coordinate patient care to become more cost-effective in using available healthcare dollars while achieving positive patient outcomes.

Skilled Nursing Facility VBP Program Criteria

The ACA introduces the SNF VBP program, appointing HHS with the responsibility to develop the program. The HHS Secretary was to issue a report to Congress on the SNF VBP program on or before October 1, 2011, but the program development has been in the works for years already. In 2009, CMS initiated its three-year Nursing Home Value-Based Purchasing Demonstration (Demonstration) project. The Demonstration is intended to provide financial incentives to those SNFs that demonstrate a “reduction in avoidable hospitalizations” with expected results of “savings to Medicare that will be used to fund the incentive payments.” The savings will fund a performance payment pool from which the top performing nursing homes will receive payments. There are certain performance measures, i.e. improvement or attainment of quality care in several areas, that the SNF must achieve before receiving any performance payments. The eventual design of the SNF VBP program on or before October 1, 2011, but the program development has been in the works for years already. In 2009, CMS initiated its three-year Nursing Home Value-Based Purchasing Demonstration (Demonstration) project. The Demonstration is intended to provide financial incentives to those SNFs that demonstrate a “reduction in avoidable hospitalizations” with expected results of “savings to Medicare that will be used to fund the incentive payments.” The savings will fund a performance payment pool from which the top performing nursing homes will receive payments. There are certain performance measures, i.e. improvement or attainment of quality care in several areas, that the SNF must achieve before receiving any performance payments. The eventual design of the SNF VBP program likely will be informed by the final evaluation of the demonstration project.

The SNF VBP performance measures are specific to the industry and will be refined further after the Demonstration. The Demonstration uses four performance measures, each given different weight, which combine to make the “quality” composite score upon which the performance payments are based. The Staffing and Appropriate Hospitalization measures constitute 30% each of the quality score while the Minimum Data Set Outcomes and Survey Deficiencies measures each represent 20% of that score. The top 20% in overall performance and top 20% of those who improved performance qualify for the performance payments. Additionally, the top 10% in a category qualify for a higher performance payment; however, SNFs that qualify in more than one category (i.e. overall performance or attainment) receive only the higher of the two available performance payments. The payments will be weighted based on resident census during the review period.

Measuring Quality

Linking payment to patient outcomes and cost-efficiency is the program goal and incentive payments will be given to those PAC providers who attain or improve upon quality outcomes. High-quality outcomes for Medicare beneficiaries may include decreased hospitalizations, shorter stays, and fewer adverse events. Reducing avoidable hospitalizations as an improvement goal also results in marked savings to the Medicare program. Cost-efficiency goals focus on coordinating care to avoid duplicative services billed by multiple providers. The unnecessary duplication of services by multiple providers for the same patient has resulted in significant costs to the Medicare system. The combination of coordinated care and improved patient outcomes results in savings to the Medicare program overall. Measuring “quality,” however, is unfairly subjective unless its definition is grounded in universally recognized and accepted principles.

The federal government has attempted to provide an objective measurement for “quality” through identifying and developing evidence-based and expert-endorsed resources for the healthcare industry’s use. One such example is the AHRQ’s Evidence-Based Practice Center (EPC). These efforts, however, have primarily been directed to practices found in acute care hospitals. Most SNF providers are accustomed to quality of care surveys that are inconsistent throughout the United States. While reliance upon objective bases for standardized quality measurements is the federal government’s eventual goal, it remains to be seen if SNFs in different states, surveyed by different agencies, and reviewed by different individuals can rely upon evidence-based and expert-endorsed standards to identify, improve upon, and attain “quality” measures.
Economically, administrative costs unquestionably will increase with the implementation of a VBP program. Existing regulatory documentation requirements do not include the type of quality data collection contemplated in typical VBP programs. New data collections sets may include resource use reporting, coordination of care paperwork, and events-reporting (e.g., avoidable hospitalizations). CMS is not unmindful of these increased costs realities. In fact, CMS is actively seeking the industry’s input on addressing these increased costs.

PAC providers can use the VBp program as a launch pad to a new paradigm without necessarily getting stuck in the quagmire of increased costs and regulatory oversight concerns. The federal government is encouraging an engaged, aging consumer base to become more educated about its healthcare dollars and treatment options. PAC providers should use this time of transition from the traditional fee-for-service model to innovate treatment options and be ahead of the learning curve when performance payments for improved quality outcomes become available.

Other Healthcare Providers
CMS has a number of initiatives that are projected to begin in the next year or so. These initiatives often follow previous pilot pay-for-performance projects and address almost every facet of the healthcare delivery system.

Home Health Agencies
Like other providers, home health agencies (HHAs) will be subject to a VBP program in the future. In anticipation of such a program, CMS conducted a pay-for-performance demonstration project for HHAs from January 1, 2008 to December 31, 2009. After the first year of the project, CMS shared more than $15 million in savings with 166 HHAs based on their performance during that year. As required under the ACA, in February 2011 CMS announced the start of its focus on Home Health Value Based Purchasing (HH VBP). CMS sought input from the provider community on how to structure the HH VBP program, particularly in areas of concern to providers such as data selection, collection and validity, the reporting format, payment structures, bonus payments, and public disclosures. Like the SNF VBP program, CMS was required to submit a report containing this plan to Congress not later than October 1, 2011.

Ambulatory Surgical Centers (ASC)
On April 18, 2011, HHS submitted a report to Congress outlining HHS’ plan to implement a VBP program for Medicare payments to ASCs. According to the report, ASCs are the fastest growing type of hospital- and/or physician-owned facility that participates in Medicare and are becoming a critical component of the healthcare system. While use of, and Medicare payments to, ASCs has increased, quality oversight
has not kept pace. Noting the increasing numbers of healthcare-associated infections in ASCs, HHS urged Congress to adopt an ACS VBP program similar to those adopted for hospitals and proposed for other healthcare providers. HHS intends to use the quality measures developed by the ASC Quality Collaboration and endorsed by the National Quality Forum as quality-reporting measures in the ACS VBP program. Those measures address patient burns, falls, and hospital transfer/admission, among others.

Value Based Payment Modifier Under the Physician Fee Schedule.
The ACA also establishes a VBP payment modifier to provide for differential payment to a physician or a group of physicians under their fee schedule, based on the quality of care furnished to their patients and compared to the costs during a performance period.45 This project also is to be budget neutral, like the Hospital VBP program, and will be coordinated with the Physician Feedback Program. The ACA requires CMS to publish by January 1, 2012 the quality of care measures, the dates for implementation of the payment modifier and the initial performance period, as well as the costs associated with the project. HHS must begin implementing the payment modifier through the rulemaking process during 2013 and by January 1, 2015, the payment modifier must be applied to specific physicians and groups of physicians (as determined by HHS). By January 1, 2017, HHS must apply the modifier to all physicians and physician groups.

Other Providers
While not on the immediate horizon, the ACA requires HHS to initiate VBP pilot projects for psychiatric hospitals and units, long term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs.46 The programs must be initiated by 2016, giving HHS plenty of time to evaluate the VBP projects currently underway and make corrections where needed.

Conclusion
The current and pilot projects on VBP are intended to bring about transformational total care delivery changes and increase the level of shared accountability among providers. Thus, it is essential that healthcare providers keep current with these initiatives, as these VBP programs will be transitioning and expanding further over the next few years. Since the anticipated overall outcome is to reduce Medicare spending per beneficiary and improve care outcomes, leaders should be preparing now rather than sitting back and awaiting implementation deadlines.

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About the Authors
Barb Miltenberger (Barbara.Miltenberger@huschblackwell.com) is a senior partner at Husch Blackwell’s Jefferson City, MO, office. She is also a registered nurse and serves on AHLA’s Board of Directors. Ms. Miltenberger advises local, regional, and national long term care, assisted living, home health, and hospice organizations on survey compliance, Medicare and Medicaid, fraud and abuse, licensing issues, and reimbursement matters. She also advises hospital systems clients on quality measures and survey compliance issues.

Sarah Downs (sarah.downs@huschblackwell.com), an attorney in Husch Blackwell’s Denver, CO, office, represents a variety of healthcare providers, including hospitals, health systems, and physician practices. She advises providers on healthcare law issues including regulatory compliance, hospital-physician arrangements, and compliance investigations. Ms. Downs has also assisted clients with hospital-physician joint ventures, asset purchase agreements, and related due diligence, employment arrangements, and physician practice mergers.

Laura A. Greene (laura.greene@huschblackwell.com) is an attorney in Husch Blackwell LLP’s Springfield, MO, office. Ms. Greene advises post acute care providers and hospital systems on survey compliance, fraud and abuse, and licensing matters. She also assists clients with physician practice management and related employment issues.
Endnotes


2 On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) 124 Stat. 119 (PPACA) was enacted. On March 30, 2010, the Health Care and Education Reconciliation Act (Pub. L. No. 111-152) (HCERA) amended certain portions of the PPACA. Together they are known as the Affordable Care Act (ACA).

3 ACA § 3001.


11 Id. at 26499.

12 Id. at 26512.

13 It is unclear from CMS’ comments whether the dates for the FY 2014 Mortality Measures also apply to the Process of Care and Experience of Care Measures. See id. at 26495.


17 Id. at 26511.


20 ACA § 3006.


22 ACA § 3006.

23 As of this publication date, HHS/CMS had not confirmed that report was prepared or presented.


25 Id.

26 Id.

27 Id.

28 Id.

29 Id.

30 Id.


32 In addressing coordination of care in the context of Accountable Care Organizations, the claim is made that Medicare could save $960 million over three years” through avoiding duplicative and unnecessary services. Accountable Care Organizations: Improving Care Coordination for People with Medicare, available at www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html (last accessed Nov. 27, 2011).


36 The CMS June 24, 2008 Open Door Forum on the Five Star Rating System addressed an industry request to include resident satisfaction survey results in the System. The CMS Director of the Survey and Certification Group focused on the lack of consistency and objective measurements in resident satisfaction surveys when disagreeing with the request.


39 See, e.g., Adrian Slywotzky and Tom Main, The Quiet Health-Care Revolution, The Atlantic 92-98 (Nov. 2011).

40 CMS Press Release, Medicare’s Home Health Pay for Performance Demonstration (May 6, 2010), available at www.cms.gov/apps/media/press/release.asp?Counter=3737&intNumPerPage=10&checkDate=&checkKey=&archType=1&numDays=3500&archOpt=&archData=&keywordType=All&chkNewsType=1%2C2%2C3%2C4%2C5&startPage=&showAll=1&Year=&year=&desc=false&cboOrder=date (last accessed on Dec. 15, 2011).

41 ACA § 3006.

42 At the time of the writing of this article, no such report could be found.


45 ACA § 3007.

46 ACA § 10326.