



Healthcare Association
of New York State

SUMMARY OF THE FFY 2013 MEDICARE VALUE-BASED PURCHASING PROPOSED RULE

February 2011

**HEALTHCARE ASSOCIATION
OF NEW YORK STATE**
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SUBMISSION OF COMMENTS

This document provides an overview of the Medicare value-based purchasing proposed rule for federal fiscal year (FFY) 2013.

The Centers for Medicare and Medicaid Services (CMS) must receive comments on the proposal by March 8 at 5 p.m. CMS requests that comments reference the file code CMS-3239-P.

Comments on the proposed rule can be submitted electronically at <http://www.regulations.gov>. Click on the “Submit Electronic Comments on CMS Regulations With an Open Comment Period” link (attachments should be in Microsoft® Word, WordPerfect, or Excel format).

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I. OVERVIEW

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established a pay-for-reporting program now called the “Hospital Inpatient Quality Reporting” (IQR) program. The Hospital IQR program reduced the Inpatient Prospective Payment System (IPPS) standardized amount by 0.4 percentage points beginning FFY 2005 for those IPPS hospitals that did not submit required quality data.

Subsequently, the Deficit Reduction Act (DRA) of 2005 expanded the reporting and increased the payment reduction for the Hospital IQR program to 2.0 percentage points effective FFY 2007 and subsequent years. Additionally, the DRA mandated the Centers for Medicare and Medicaid Services (CMS) to develop and provide to Congress a report on a Medicare hospital inpatient value-based purchasing (VBP) program. As a result, CMS issued the *2007 Report to Congress: Plan to Implement a Medicare Hospital VBP Program*. The Affordable Care Act (ACA) of 2010 requires implementation of a Medicare inpatient hospital VBP program, linking payment to quality performance for acute care hospitals paid under IPPS starting FFY 2013.

In the January 13, 2011 *Federal Register*, CMS released its proposed rule to implement, beginning federal fiscal year (FFY) 2013, the Medicare VBP program. CMS’ proposed rule begins the process of implementing the first mandatory hospital delivery system reform mandated by ACA.

VBP, a pay-for-performance program, will link Medicare inpatient payment to quality performance for acute care hospitals paid under IPPS.

Drawing from a subset of clinical process of care quality measures and patient satisfaction measures currently reported under the Hospital IQR program, hospitals can earn points towards a VBP score for achievement of certain quality standards and hospital-specific improvement in care quality. A total VBP score for each hospital is calculated as a basis for determining a hospital’s VBP incentive payment.

Changes are effective October 1, 2012, unless otherwise noted. CMS used the *2007 Report to Congress: Plan to Implement a Medicare Hospital VBP Program* as a foundation for this proposed rule. The *Report* discussed VBP program options, building on the current Hospital IQR program.

Note: Text in italics is extracted from the January 13, 2011 *Federal Register*.

ACA REQUIREMENTS FOR VBP

ACA requires implementation of the hospital VBP program in FFY 2013. The VBP program will be funded by Medicare inpatient payment reductions, beginning with a 1% reduction in FFY 2013 that increases by 0.25% each year until the reduction reaches 2% for FFY 2017 and subsequent years. The VBP must be budget-neutral, with each year’s funding pool fully distributed to hospitals that same year.

The VBP program applies to all “subsection (d)” inpatient hospitals—all hospitals under the Inpatient PPS, excluding psychiatric, rehabilitation, children’s, cancer, and long-term care hospitals. CAHs and small hospitals with insufficient numbers of measures and/or cases are excluded. Within two years, the Secretary of Health and Human Services (HHS) must establish two separate, three-year VBP demonstration programs, one for CAHs and one for these small excluded hospitals. Each of the demonstration programs will culminate in a report to Congress and recommendations for permanent VBP programs.

The HHS Secretary is responsible for selecting measures, and determining the scoring and payment methodologies. In FFY 2013, measures must cover at least the following conditions: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), surgeries from the Surgical Care Improvement Project (SCIP), and health care-associated infections (HAIs). Measures must also be selected from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. No earlier than FFY 2014, the Secretary is required to include efficiency measures (including adjusted Medicare spending per beneficiary) as part of the VBP program. The use of readmissions measures as part of the VBP program is expressly prohibited. The methodology is required to recognize both achievement of standards and improvement.

STRUCTURE OF THE CMS-PROPOSED VBP METHODOLOGY

Quality Measures

For FFY 2013, CMS proposes to incorporate a clinical process of care domain with 17 measures covering AMI, HF, PN, surgeries using SCIP measures, and healthcare-associated infections (HAIs) as measured by SCIP. These measures are currently reported on the Hospital Compare Web site. CMS also proposes to include a patient experience of care domain in FFY 2013 with eight measures related to the HCAHPS survey.

In FFY 2014, CMS proposes to add an outcome domain, including three mortality measures, eight HAC measures, and nine Agency for Healthcare Research and Quality (AHRQ) measures.

Performance Period and Baseline Period

For FFY 2013, CMS is proposing a performance period comprised of measures reported by hospitals from July 1, 2011 through March 31, 2012. These data will be used to determine a hospital's achievement score when compared to national standards, and the improvement score when compared to the hospital's score from the baseline period.

For FFY 2013, CMS is proposing a baseline period comprised of measures reported by hospitals from July 1, 2009 through March 31, 2010. The baseline period data will be used to set the VBP achievement standards and to measure hospital improvement.

Calculating the Hospital Total Performance Score

Achievement and improvement scores would be calculated for each individual measure and hospitals will receive the higher of the two scores. CMS proposes to combine individual measure scores within each domain, giving each measure equal weight. The composite scores for each domain would be multiplied by a domain weight and added together to determine each hospital's VBP total performance score. CMS proposes to weight the clinical process of care domain at 70% and the patient experience of care domain at 30%. In future years, the weighting will be revised to incorporate the outcome domain.

Payout Function

Funds carved out of the Medicare payment rates will be redistributed to hospitals based on their VBP total performance scores. CMS proposes to determine each hospital's VBP incentive payment using a "linear function" that starts at zero and increases the percent of the rate reduction that is returned to the hospital as the VBP score increases. All hospitals with a score above zero will receive some level of incentive payment from the VBP pool. The VBP incentive will be less than the rate reduction for hospitals with low VBP scores, while high performing hospitals will experience a net increase in payments.

II. QUALITY MEASURES

Federal Register pages 2458-2463

ACA requires the HHS Secretary to select measures reported for the Hospital IQR program. There are 45 measures reported under the FFY 2011 Hospital IQR program. CMS intends to give priority to those measures that assess performance on high-volume conditions, and have the highest mortality rates and the widest variation in cost and treatment patterns. CMS also plans to select measures that address the six quality aims articulated in the Institute of Medicine study, *Crossing the Quality Chasm* of effective, safe, timely, efficient, patient-centered, and equitable health care.

CMS' current and long-term priority areas include: *“prevention and population health; safety; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections improved care coordination; improved efficiency; improved patient and family experience of care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; adoption and use of interoperable health information technology.”* CMS believes that these criteria and priorities are consistent with the ACA requirements that the Hospital IQR program is coordinated and aligned with the quality reporting programs applicable to physicians and other Medicare providers.

ACA mandates that the VBP measures for FFY 2013 include at least the following conditions:

- AMI;
- HF;
- PN;
- surgeries, as measured by SCIP;
- HAIs; and
- HCAHPS.

Readmission measures are specifically excluded from the VBP program. ACA also requires that all VBP measures be reported on the CMS Hospital Compare Web site for at least one year before the beginning of the performance period.

TOPPED-OUT MEASURES

Federal Register pages 2460-2461

CMS' Proposal: In determining which Hospital IQR measures to include in the Hospital VBP program, CMS evaluates whether a hospital's performance on the measure is “topped-out.” According to CMS, a measure is topped-out if all but a few hospitals have achieved a similarly high level of performance for that measure. CMS believes *“that measuring hospital performance on topped-out measures will have no meaningful effect on a hospital's total performance score.”*

CMS proposes to exclude seven topped-out IQR measures: AMI-1 Aspirin at Arrival; AMI-5 Beta Blocker at Discharge; AMI-3 ACEI or ARB at Discharge; AMI- 4 Smoking Cessation; HF-4 Smoking Cessation; PN-4 Smoking Cessation; and SCIP-Inf-6 Surgery Patients with Appropriate Hair Removal.

FFY 2013 VBP QUALITY MEASURES

Federal Register pages 2458-2463

CMS' Proposal: CMS reviewed all 45 Hospital IQR measures as possible candidates for the Hospital VBP. After excluding readmission measures, measures not reported on the Hospital Compare Web site for at least one year, and topped-out measures, CMS is proposing to include 17 measures in the FFY 2013 VBP as shown below:

Proposed Hospital VBP Measures for FFY 2013

Clinical Process of Care Domain

| Acute Myocardial Infarction (AMI) | |
|--|---|
| AMI-2 | Aspirin Prescribed at Discharge |
| AMI-7a | Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival |
| AMI-8a | Primary Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival |

| Heart Failure (HF) | |
|---------------------------|---|
| HF-1 | Discharge Instructions |
| HF-2 | Evaluation of LVS Function |
| HF-3 | ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) |

| Pneumonia (PN) | |
|-----------------------|---|
| PN-2 | Pneumococcal Vaccination |
| PN-3b | Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital |
| PN-6 | Initial Antibiotic Selection for CAP in Immunocompetent Patient |
| PN-7 | Influenza Vaccination |

| Healthcare-Associated Infections (as measured by SCIP measures) | |
|--|--|
| SCIP-Inf-1 | Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision |
| SCIP-Inf-2 | Prophylactic Antibiotic Selection for Surgical Patients |
| SCIP-Inf-3 | Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time |
| SCIP-Inf-4 | Cardiac Surgery Patients with Controlled 6 AM Postoperative Serum Glucose |

| Surgeries (as measured by SCIP measures) | |
|---|---|
| SCIP-Card-2 | Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period |
| SCIP-VTE-1 | Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered |
| SCIP-VTE-2 | Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery |

Patient Experience of Care Domain

| Patient Satisfaction Survey | |
|--|---|
| Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey | Eight Dimensions: <ul style="list-style-type: none"> • Communication with Nurses • Communication with Doctors • Responsiveness of Hospital Staff • Pain Management • Communication About Medicines • Cleanliness and Quietness of Hospital Environment • Discharge Information • Overall Rating of Hospital |

FFY 2014 VBP QUALITY MEASURES

Federal Register pages 2461-2463

CMS' Proposal: CMS proposes to add an outcome domain to the VBP program in FFY 2014. This would include the publicly-reported risk-adjusted, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack, heart failure, or pneumonia. CMS would establish an 18-month performance period from July 1, 2011 to December 31, 2012 for the mortality measures. CMS also proposes to add eight HAC measures, and nine AHRQ measures as shown below:

Proposed Hospital VBP Measures for FFY 2014

Outcome Domain

| Mortality Measures | |
|--------------------|--|
| Mort-30-AMI | Acute Myocardial Infarction 30-day mortality (Medicare patients) |
| Mort-30-HF | Heart Failure 30-day mortality (Medicare patients) |
| Mort-30-PN | Pneumonia 30-day mortality (Medicare patients) |

| Agency for Healthcare Research and Quality (AHRQ) Measures | |
|--|---|
| PSI-06 | Iatrogenic pneumothorax, adult |
| PSI-11 | Postoperative respiratory failure |
| PSI-12 | Postoperative PE or DVT |
| PSI-14 | Postoperative wound dehiscence |
| PSI-15 | Accidental puncture or laceration |
| IQI-11 | Abdominal aortic aneurysm mortality rate (with or without volume) |
| IQI-19 | Hip fracture mortality rate |
| | Mortality for selected medical conditions |
| | Complications/patient safety for selected indicators |

Hospital-Acquired Conditions

| Hospital-Acquired Conditions (HACs) Measures |
|--|
| Foreign object retained after surgery |
| Air embolism |
| Blood incompatibility |
| Pressure ulcer stages III & IV |
| Falls and trauma (includes: fracture, dislocation, intracranial injury, crushing injury, burn, electric shock) |
| Vascular catheter-associated infection |
| Catheter-associated urinary tract infection (UTI) |
| Manifestations of poor glycemic control |

CMS also requested comments on the potential addition of nursing sensitive care measures to the VBP in FFY 2014 or in a subsequent year.

VBP EFFICIENCY MEASURES

Federal Register page 2463

ACA requires CMS to include efficiency measures beginning in FFY 2014, or a subsequent fiscal year. The efficiency measures must include “Medicare Spending per beneficiary” adjusted for factors such as age, sex, race, severity of illness, and other factors determined to be appropriate by the Secretary.

CMS’ Proposal: CMS has not proposed any specific efficiency measures in this rule, but solicits input on these measures. CMS requests comment on which services should be included in a “Medicare spending per beneficiary” calculation. CMS also requests input on potential hospital segmentation and adjustments that should be considered. CMS is considering development of internal hospital efficiency measures to assess hospital spending per admission using cost reports or other data sources.

ADDITIONAL MEASURES IN SUBSEQUENT YEARS

Federal Register pages 2458-2463

CMS’ Proposal: CMS is proposing to implement a “subregulatory” process to expedite the timeline for adding measures to the Hospital VBP program. CMS is “*proposing to add additional measures to the Hospital VBP program in the future in such a way that their performance period will begin immediately after they are displayed on Hospital Compare for a period of time of at least one year, but without the necessity of notice and comment rulemaking.*” New measures would be added once they have met the one year aging-in criteria. CMS would solicit comments on the appropriateness of adopting each measure and notify the public of the final decisions.

CMS is also proposing to implement a “subregulatory” process to retire Hospital VBP measures. Under this process, CMS would post its intention to retire measures on the CMS Web site at least 60 days prior to the date that the measure would be eliminated.

ALIGNMENT OF ELECTRONIC HEALTH RECORDS (EHRs)

Federal Register page 2485

Beginning in FFY 2011, the Health Information Technology for Economic and Clinical Health Act (HITECH) Act authorized payment incentives under Medicare for the adoption and use of certified EHR technology. Hospitals become eligible for these incentive payments if certain requirements are met for becoming a meaningful user of certified EHR technology, which include reporting on quality measures using certified EHR technology. According to CMS, “*the Hospital IQR program and Hospital VBP Program have important areas of overlap and synergy with respect to the reporting of quality measures under the HITECH Act using EHRs. We believe the financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the Hospital IQR program which are subsequently used for the Hospital VBP Program.*”

CMS is not proposing to implement any HITECH statutory provisions in this proposed rule, and states that those provisions are the subject to a separate rulemaking and public comment process.

VALIDATION REQUIREMENTS

Federal Register pages 2484-2485

Background: In the final FFY 2011 IPPS rule, CMS adopted a validation process to be applied to the FFY 2013 Hospital IQR program.

CMS' Proposal: For the FFY 2013 Hospital VBP program, CMS is proposing to adopt the same validation process that was adopted for the Hospital IQR program. *“We believe that using this process for both the Hospital IQR program and the Hospital VBP program is beneficial for both hospitals and CMS because no additional burden will be placed on hospitals to separately return requested medical records for the Hospital VBP program.”*

III. MINIMUM REQUIREMENTS AND EXCLUSIONS

Federal Register pages 2479-2481

Background: ACA specifies that only subsection (d) hospitals may participate in the VBP program. A subsection (d) hospital is defined as *“a hospital located in one of the fifty States or the District of Columbia.”* The definition of a subsection (d) hospital does not include hospitals and hospital units excluded from IPPS, such as psychiatric, rehabilitation, long-term care, children’s, cancer, or Critical Access Hospitals (CAHs).

CMS' Proposal: In addition to restricting participation in the VBP program to only subsection (d) hospitals, CMS is proposing to exclude from the VBP program:

- hospitals cited by the Secretary for deficiencies that pose immediate jeopardy to the health or safety of patients—as required by ACA;
- hospitals that do not meet the requirement for the hospital IQR program from the Hospital VBP program for that applicable year;
- any hospital to which less than four of the proposed clinical process of care domain measures apply; and
- hospitals that do not report a minimum of 100 HCAHPS surveys during the performance period.

In addition, CMS proposes to exclude from a hospitals’ total performance score calculation any measures for which they reported fewer than ten cases in the performance period.

Regarding small hospitals, CMS states, *“As might be expected, a significant portion of hospitals not receiving a Hospital VBP score are small providers because such entities are more likely to lack the minimum number of cases or measures required to participate in the Hospital VBP program. We anticipate conducting future research on methods to include small hospitals in the Hospital VBP program.”*

There is no other proposal for identifying small hospitals to be excluded from the VBP program.

IV. BASELINE AND PERFORMANCE PERIOD

Federal Register pages 2457-2458

ACA mandates notification timeframes for the data that will be used to calculate VBP scores. ACA states that the performance period must begin and end before the FFY in which the VBP incentive payment begins. The baseline period data will be used to calculate the starting point for an improvement score and to set the performance standards for achievement scores. ACA requires the Secretary to announce performance standards no later than 60 days before the beginning of the performance period for the applicable fiscal year.

Performance Period

CMS' Proposal: CMS proposes that the performance period begin at the start of a quarter to align with the submission of Hospital IQR data. ACA requires that hospitals be notified of their VBP adjustment 60 days prior to the start of the FFY in which it will be applied. To meet this mandate and allow for the time for CMS to process the submitted measure data, CMS proposes to establish the nine-month period from July 1, 2011 to March 31, 2012 as the performance period for the FFY 2013 VBP program.

The timeframe needed to calculate total performance scores and incentive payments, and to notify hospitals regarding their payment adjustments does not allow CMS to use a full 12 months of Hospital IQR program data

for FFY 2013. However, CMS anticipates using a full four quarters of data for future performance periods.

Lastly, CMS proposes to add mortality measures in FFY 2014, using an 18-month interval with the performance period beginning July 1, 2011 through December 31, 2012.

Baseline Period

CMS' Proposal: CMS proposes to use a nine-month period that mirrors the performance period to avoid seasonality issues. ACA requires that CMS establish and announce the performance standards at least 60 days before the beginning of the performance period. Therefore, CMS proposes to establish the nine-month period from July 1, 2009 to March 31, 2010 as the baseline period for the FFY 2013 VBP.

V. PERFORMANCE STANDARDS

Federal Register pages 2463-2464

Background: ACA requires that the Secretary:

- establish performance standards for the measures selected in the VBP program;
- standards must include levels of achievement and improvement; and
- standards must be released 60 days before the start of the performance period.

CMS' Proposal: CMS proposes that the achievement threshold for each VBP measure be set at the median of hospital performance (50th percentile) during the baseline period. Only hospitals that exceed the achievement threshold would receive achievement points. CMS has not completed the process for validating the data for the proposed baseline period; therefore, the precise values for the achievement thresholds are not yet available and will be specified in the final rule. The improvement threshold for each measure will be based on each hospital's own performance during the baseline period.

VI. VBP SCORING METHODOLOGY

Federal Register pages 2464-2479

Background: ACA requires the Secretary to develop a methodology for assessing a hospital's performance on each measure. Hospital performance must be evaluated for each measure based on the higher of achievement or improvement. CMS proposes to apply a methodology that is similar to the Performance Assessment Model that was presented in the *2007 Report to Congress*. Under the Performance Assessment Model, a hospital could earn zero to ten points for achievement on each measure based on its performance relative to national standards. In addition, a hospital could earn zero to nine points for improvement based on its performance on each measure during the performance period compared to the baseline period.

PROCESS OF CARE DOMAIN SCORE

Federal Register pages 2466-2470

Achievement Points

CMS' Proposal: CMS is proposing to calculate achievement points for each process of care measure by comparing a hospital's performance in the "performance year" to a national benchmark (the mean of the top decile of hospital performance during the baseline period) and achievement threshold (50th percentile of hospital performance on the measure during the baseline period). A hospital could earn up to ten points for achievement on each measure.

CMS proposes "that hospitals would receive points along an achievement range, which is a scale between the achievement threshold (the minimum level of hospital performance required to receive achievement points) and the benchmark" Therefore, the closer a hospital's score is to the national benchmark, the more achievement points a hospital can earn. If a hospital's score during the performance year was:

- "Equal to or greater than the benchmark, the hospital would receive **10 points** for achievement;
- Equal to or greater than the achievement threshold (but below the benchmark), the hospital would receive a **score of 1-9** based on a linear scale established for the achievement range (which distributes all points proportionately between the achievement threshold and the benchmark so that the interval in performance between the score needed to receive a given number of achievement points and one additional achievement point is the same throughout the range of performance from the achievement threshold to the benchmark);
- Less than the achievement threshold (that is, the lower bound of the achievement range), the hospital would receive **0 points** for achievement."


The points for performance that falls in the range between the achievement threshold and the benchmark would be calculated using the following formula:

$$9 * ((\text{Hospital's performance period score} - \text{achievement threshold}) / (\text{benchmark} - \text{achievement threshold})) + .5$$

Example of Scoring Achievement Points

Process of Care Measure: PN-2 -- Pneumococcal Vaccination

| | |
|-------------------------------------|-----|
| National Benchmark * | 87% |
| Achievement Threshold * | 47% |
| Hospital A Baseline Period Score | 21% |
| Hospital A Performance Period Score | 70% |

| Calculation of an Achievement Score | | |
|--|--|----------|
| Hospital A Performance Period Score | 70% | |
| Achievement Threshold | 47% | |
| <i>Hospital A Performance Period Score minus Achievement Threshold</i> | | 23% |
| National Benchmark | 87% | |
| Achievement Threshold | 47% | |
| <i>National Benchmark minus Achievement Threshold</i> | | 40% |
| Achievement Points Earned for this Measure $(9 * (23\% / 40\%)) + .5$ |  | 6 |

*The National Benchmark and Achievement Threshold amounts shown in this example are estimates only. CMS will publish the final benchmarks and thresholds in the final rule.

Improvement Points

CMS’ Proposal: CMS proposes that a hospital could earn up to nine points based on how much its performance on the measure during the performance period improved from its performance on the measure during the baseline period.

CMS is proposing “if a hospital’s score on the measure during the performance period was:

- Greater than its baseline period score but below the benchmark (within the improvement range), the hospital would receive a **score of 0-9** based on the linear scale that defines the improvement range; or
- Equal to or lower than its baseline period score on the measure, the hospital would receive **0 points** for improvement.”


The points for improvement when performance falls in the range from the hospital’s baseline period score to the benchmark would be calculated using the following formula:

[10 * ((Hospital performance period score - Hospital baseline period score) / (Benchmark - Hospital baseline period score))] - .5

Example of Scoring Improvement Points

Process of Care Measure: PN-2 -- Pneumococcal Vaccination

Note: In this example Hospital A's score for the performance period is greater than its score in the baseline period, therefore, an improvement score needs to be calculated.

| Calculation of an Improvement Score | | |
|---|--|----------|
| Hospital A Performance Period Score | 70% | |
| Hospital A Baseline Period Score | 21% | |
| <i>Hospital A Performance Period Minus Hospital A Baseline Period Score</i> | | 49% |
| National Benchmark | 87% | |
| Hospital Baseline Period Score | 21% | |
| <i>National Benchmark Minus Baseline Period Score</i> | | 66% |
| Improvement Points Earned for this Measure ([10* (49% / 66%)] -5) |  | 7 |

In this example Hospital A would receive 7 points for this measure, because the improvement score is higher than the achievement score.

OVERALL PROCESS OF CARE DOMAIN SCORE

Federal Register pages 2470-2471

CMS’ Proposal: CMS is proposing “that both a hospital’s overall clinical performance score and outcome performance score would be based on all measures that apply to the hospital.” CMS is also proposing “that at least four measures within a domain must apply to the hospital in order for the hospital to receive a performance score on that domain” (Refer to the “Minimum Requirements and Exclusions” section above.)

“Because the clinical process of care . . . performance scores will be based only on the measures that apply to the hospital, we propose to normalize the domain scores across hospitals by converting the points earned for each domain to a percentage of total points.”

Hospital A shown in the example above would receive the higher of its achievement or improvement points,

which in the example results in seven points for the PN-2 measure. To calculate the overall process of care domain score, Hospital A’s PN-2 points would be included with all the other applicable process of care measure points for the hospital as illustrated below.

Example Calculation of the Process of Care Domain Score

| | |
|---|----------------------|
| PN-2 Process of Care Measure Points Earned (from example above) | 7 |
| HF-1 Process of Care Measure Points Earned | 5 |
| AMI-2 Process of Care Measure Points Earned | 3 |
| SCIP-Inf-2 Process of Care Measure Points Earned | 10 |
| Hospital A's Total Points Earned for Process of Care Measures Reported | 25 |
| Total Possible Points (4 process measures reported * 10 points) | 40 |
| Hospital A's Process of Care Domain Score | (25/40) *100% |
| | 62.5% |

PATIENT EXPERIENCE OF CARE DOMAIN SCORE (HCAHPS)

Federal Register pages 2471-2475

CMS’ Proposal: For FFY 2013, CMS proposes “to score each of the eight HCAHPS dimensions using an approach that parallels the one we are proposing to use to score the clinical process measures, using an achievement point range from 0–10 and an improvement point range from 0 to 9, with the total score on each HCAHPS dimension being the higher of the achievement or improvement score.”

CMS proposes to base the HCAHPS scores on the publicly reported adjusted proportions of the best category (“Top Box”) responses. The “Top Box” responses are the most positive responses submitted for each question on the HCAHPS survey. For example, the score for nurse communication would be based on the proportion of survey responses indicating that nurses “always” communicated well.

HCAHPS scores would be based on the percentile rank for the hospital’s score on each measure. For each HCAHPS dimension, the national benchmark is set at the 95th percentile of performance in the base period and the achievement threshold is set at the 50th percentile (in contrast, to the process of care measures where the national benchmark represents the mean performance score for the top decile and the achievement threshold represents the 50th percentile of hospital performance for each measure). Up to 20 additional consistency points can be earned based on a hospitals’ overall HCAHPS performance (described in detail below).

CMS proposes “that, for inclusion in the Hospital VBP program for FY 2013, hospitals report a minimum of 100 HCAHPS surveys during the performance period.” (Refer to the “Minimum Requirements and Exclusions” section above.) CMS also proposes “to give hospitals that have 5 or fewer HCAHPS-eligible discharges in a month the option to not submit HCAHPS surveys for that month as part of their quarterly data submission.”

Achievement Points

CMS’ Proposal: CMS proposes to reward hospitals for achievement if a hospital’s performance is “at or above the proposed baseline median on each of the eight HCAHPS dimensions. A minimum score of 0 corresponds to all eight dimensions being below the baseline median (that is, the dimension-specific achievement threshold), while a maximum score of 80 corresponds to all eight dimensions being at or greater than the 95th percentile from the baseline period (that is, the dimension-specific benchmark).”


“We propose to assign 0 to 10 points for each of the eight HCAHPS dimensions as follows:

- If the hospital’s score on a dimension is equal to or greater than the benchmark (that is, the baseline 95th percentile performance), the hospital would receive 10 points for achievement on that dimension.
- If the hospital’s score on a dimension is within the achievement range (that is, equal to or greater than the achievement threshold of 50th percentile performance but below the benchmark of 95th percentile performance), the hospital would receive a score of 1-9, based on a linear scale established for the achievement range and rounding to the nearest whole point according to the following formula:

$$((\text{Hospital HCAHPS performance period dimension score} - 50) / 5) + 0.5$$
- If the hospital’s score on a dimension is less than the achievement threshold for the dimension (that is, less than the 50th percentile of performance), the hospital would receive 0 points for achievement.”

Example of Scoring Achievement Points
HCAHPS Dimension: Doctor Communication

| | |
|--|------|
| National Benchmark (Percentile) | 95th |
| Achievement Threshold (Percentile) | 50th |
| Hospital A Baseline Period Percentile | 42nd |
| Hospital A Performance Period Percentile | 64th |

| Calculation of an Achievement Score | | |
|--|--|----------|
| Hospital A Performance Period Percentile | 64th | |
| Achievement Threshold Percentile | 50th | |
| <i>Hospital A Performance Period Percentile Minus Achievement Threshold Percentile</i> | | 14 |
| Achievement Points Earned for this Dimension $((64 - 50)/5) + 0.5$ |  | 3 |

Improvement Points

CMS’ Proposal: CMS proposes “For each HCAHPS dimension, a hospital could earn from 0-9 improvement points for each dimension depending on how much its performance on the dimension improved from its performance on the dimension during the baseline period.”

“If a hospital’s score on the measure during the performance period was:

- Greater than its baseline period score but below the benchmark (within the improvement range), the hospital would receive a score of 0-9 based on the linear scale that defines the improvement range
- Equal to or lower than its baseline period score on the measure, the hospital would receive 0 points for improvement.
- If there is no improvement or if the score from the baseline period was already at the benchmark, the improvement score is 0.”

The points for improvement when performance falls in the range from the hospital’s baseline period score to the benchmark would be calculated using the following formula:

$$[10 * ((\text{Hospital performance period score} - \text{Hospital baseline period score}) / (\text{Benchmark} - \text{Hospital baseline period score}))] - 0.5$$

Example of Scoring Improvement Points

HCAHPS Dimension: Doctor Communication

Note: In this example Hospital A's performance period is greater than its performance in the baseline, therefore, an improvement score needs to be calculated.

| Calculation of an Improvement Score | | |
|--|------|----------|
| Hospital A Performance Period Percentile | 64th | |
| Hospital A Baseline Period Percentile | 42nd | |
| <i>Hospital A Performance Period Minus Hospital A Baseline Period Percentile</i> | | 22 |
| National Benchmark Percentile | 95th | |
| Hospital A Baseline Period Percentile | 42nd | |
| <i>National Benchmark Minus Hospital A Baseline Period Percentile</i> | | 53 |
| Improvement Points Earned for this Dimension ($[10 * (22/53)] - 0.5$) | | 4 |

In this example Hospital A would receive 4 points for this HCAHPS dimension, because the improvement score is higher than the achievement score.

Consistency Points

CMS' Proposal: For FFY 2013, CMS is proposing “that hospitals earn consistency points ranging from 0-20 based on how many of their dimension scores meet or exceed the achievement threshold Consistency points are an additional form of achievement measurement that complements achievement points earned through hospital performance on individual HCAHPS dimensions.”

The consistency points (referred to as the “minimum performance score” in the 2007 Report to Congress) are intended to encourage and reward high performance on all eight HCAHPS dimensions (consistency). CMS states in the 2007 Report to Congress that its purpose is to “provide an incentive to hospitals to bring lagging scores up to at least the achievement threshold” which is “consistent with promoting wider system changes within hospitals to improve quality.”

Therefore, CMS proposes that hospitals can earn a maximum of 20 consistency points. If the minimum percentile of all eight HCAHPS dimensions for a hospital is at or above the 50th percentile, it would receive 20 points. If one or more of a hospital’s HCAHPS scores falls below the 50th percentile, the single lowest percentile would be used to calculate the consistency points by comparing it to the “worst-performing hospitals’ performance on that dimension during the baseline period,” which is always at the zero percentile. A range of zero to 20 points would be awarded proportionately according to the position of this lowest dimension score between the zero and 50th percentile of hospital performance during the baseline period.

CMS proposes the following formula to determine consistency points:

(2 * (lowest percentile / 5)) – 0.5, rounded to the nearest whole number (with a minimum of zero and a maximum of 20 consistency points)

The following example illustrates how three different hospitals would earn consistency points toward their overall Hospital VBP score.

Examples to Calculate Consistency Score

| Hospital | Hospital A | Hospital B | Hospital C | Hospital D |
|--|-------------------------|------------------------|-------------------------|-----------------------------------|
| Dimension 1 | 61th | 0th | 70th | 60th |
| Dimension 2 | 52th | 50th | 42th | 90th |
| Dimension 3 | 70th | 20th | 10th | 80th |
| Dimension 4 | 38th | 43th | 53th | 70th |
| Dimension 5 | 25th | 64th | 29th | 62th |
| Dimension 6 | 39th | 38th | 46th | 73th |
| Dimension 7 | 53th | 72th | 80th | 55th |
| Dimension 8 | 49th | 35th | 56th | 81th |
| Formula | $2*(25/5)-0.5$ = 9.5 | $2*(0/5)-0.5=$ -0.5 | $2*(10/5)-0.5$ = 3.5 | Higher than 50th percentile |
| Consistency Point (Round up to the nearest whole number) | 10 | 0 | 4 | 20 |

Note: The percentile highlighted for each hospital indicates the single lowest score the hospital received during the performance period, which is used to calculate the consistency score.

OVERALL PATIENT EXPERIENCE OF CARE DOMAIN SCORE

Federal Register page 2475

The final VBP score for each HCAHPS dimension is the higher of the achievement or improvement points (four points would be the final points earned for the HCAHPS dimensions in the example shown above). An overall VBP score for the domain is calculated by taking the sum of the final HCAHPS points plus the consistency points divided by 100 (80 points for the 8 dimensions + 20 points for consistency) which is the maximum possible HCAHPS points a hospital can earn.

Example Calculation of a Patient Experience of Care Domain Score

In this example Hospital A's lowest HCAHPS score was 25%

| | |
|--|------------|
| Doctor Communication Dimension Points Earned (from example above) | 4 |
| Dimension 2 | 5 |
| Dimension 3 | 7 |
| Dimension 4 | 9 |
| Dimension 5 | 2 |
| Dimension 6 | 5 |
| Dimension 7 | 3 |
| Dimension 8 | 8 |
| Hospital A's Base Points Earned for HCAHPS Dimensions | 43 |
| Consistency Point Earned <i>(Lowest HCAHPS Score was [(25%/50% Achievement Threshold) * 20 points (maximum number of points)] - 0.5]</i> | 10 |
| Hospital A's Total Points Earned for Patient Experience of Care Domain (Base Points + Consistency Points) | 53 |
| Hospital A's Patient Experience of Care Domain Score <i>(53 / 100 (total points earned)) * 100%</i> | 53% |

VBP TOTAL PERFORMANCE SCORE

Federal Register pages 2475-2476

CMS' Proposal: For FFY 2013, CMS proposes to calculate a “hospital’s total performance score by multiplying its performance on each domain by the proposed weight for that domain (70 percent clinical process of care, 30 percent patient experience of care), and adding those weighted scores together.”

Example of Hospital A's Overall VBP Score

(Based on the Example Shown Throughout the Summary)

| | |
|---|--------------|
| Process of Care Domain Score | 62.5% |
| Weighting of Process Measures (70%) | 0.7 |
| Weighted Process of Care Domain Score | 43.8% |
| Patient Experience of Care Domain Score | 53.0% |
| Weighting of HCAHPS (30%) | 0.3 |
| Weighted Patient Experience of Care Domain Score | 15.9% |
| Hospital A's Total VBP Calculated Score (Weighted Process of Care Domain + Weighted Patient Experience of Care Domain) | 59.7% |

VII. VBP EXCHANGE FUNCTION

Federal Register pages 2481-2483

ACA mandates that all dollars contributed toward funding the VBP program be expended in a budget-neutral manner, in the same fiscal year.

Funding

For FFY 2013, ACA requires that the VBP program be funded by a 1% reduction to the base operating Diagnosis Related Group (DRG) payments for all hospitals participating in the program, regardless of whether the hospital is eligible to receive a value-based incentive payment. CMS defines base operating DRG payments as “total payments using Medicare Part A claims data and subtracted from this number the estimates of payments made as outlier payments . . . Indirect Medical Education payments . . . Disproportionate Share Hospital payments . . . and low-volume hospital adjustment payments”

Special rules are applicable to certain hospitals regarding the payment amount, including Sole Community Hospitals (SCH) and Medicare-Dependent Hospitals (MDH). MDHs and SCHs contribute to the VBP pool based upon their federal rate calculation, regardless of whether they are paid at a hospital-specific rate.

In subsequent years, as mandated by law, the VBP pool percentage will increase by 0.25 percentage points each year not to exceed a 2% reduction for FFY 2017 and subsequent years.

Exchange Function

The exchange function is a means to translate a hospital's overall VBP total performance score into a percentage of the value-based incentive payments earned by the hospital. CMS believes a critical component to how hospitals are rewarded for their performance is determined by the selection of the exact form and slope of the exchange function.

ACA does not specify an exchange function for calculating the incentive payment percentage; however, the percent of the incentive pool earned must be determined as a function of a hospital's VBP performance scores in the applicable fiscal year.

CMS' Proposal: After examining the effects of four mathematical exchange function options (linear, cube root, cube, and logistic function), CMS is proposing a linear exchange function to translate a hospital's total performance score into the percent of the VBP incentive pool earned by the hospital.

CMS states that the linear function is the simplest and most straightforward option that would provide the same marginal incentives to all hospitals. The linear function rewards higher performing hospitals more and generates a large span of payment differences. CMS believes this linear function will ensure *"that all hospitals have strong incentives to continually improve the quality of care they provide to their patients."*

The proposed linear exchange function is the formula for a line that will start at 0% payment for an overall VBP score of zero and will end at some percentage ($x\%$) for a VBP score of 100. The $x\%$ is the slope of the line multiplied by the maximum score attainable, and will be determined based on the national distribution of VBP scores, such that the sum of all hospitals' payments will exactly equal the amount of dollars contributed to the VBP payment pool. Using this equation, each hospital's payment percentage will equal its VBP score multiplied by that slope. CMS states that *"we will set the slope of the linear exchange function for FFY 2013 so that the estimated aggregate value-based incentive payments for FFY 2013 are equal to 1 percent of the estimated aggregate base operating DRG payment amounts for FFY 2013."*

Therefore, every hospital with a score above zero will receive some VBP incentive payment, but only about half of the hospitals in the country will recoup or exceed the amount they contributed into the VBP payment pool.

VIII. HOSPITAL PAYMENT NOTIFICATION

Federal Register pages 2483-2484

Background: ACA requires hospitals be informed of the payment adjustments to their base operating DRG payment amount, no later than 60 days before the fiscal year involved.

Base Operating DRG Reduction

CMS' Proposal: CMS proposes *"to notify hospitals of the 1 percent reduction to their FFY 2013 base operating DRG payments for each discharge in the FFY 2013 IPPS rule, which will be finalized at least 60 days prior to the beginning of the 2013 fiscal year. We expect to propose to incorporate this reduction into our claims processing system in January 2013, which will allow the 1 percent reduction to be applied to the FFY 2013 discharges, including those that have occurred beginning on October 1, 2012. We will address the operational aspects of the reduction as part of the FFY 2013 IPPS rule."*

Incentive Payments

CMS' Proposal: CMS will not have sufficient time to calculate final total performance scores or final VBP incentive payment adjustments 60 days before the start of FFY 2013; therefore, CMS proposes to *"inform each hospital through its QualityNet account at least 60 days prior to October 1, 2012 of the estimated amount of its value-based incentive payment for FFY 2013 discharges based on estimated performance scoring and value-*

based incentive payment amounts, which will be derived from the most recently available data. We also propose that each hospital participating in the Hospital VBP program establish a QualityNet account if it does not already have one for purposes of the Hospital IQR program.”

CMS proposes “to notify each hospital of the exact amount of its value-based incentive payment adjustment for FFY 2013 discharges on **November 1, 2012**. The value-based incentive payment adjustment would be incorporated into our claims processing system in January 2013, which will allow the value-based incentive payment adjustment to be applied to the FFY 2013 discharges, including those that have occurred beginning on October 1, 2012.”

IX. PUBLIC DATA

Federal Register page 2484

Hospital Performance Score

Background: ACA requires information on hospitals’ VBP scores to be made available to the public including hospital performance on each applicable measure and the total hospital performance score.

CMS’ Proposal: CMS proposes to meet these requirements by publishing hospitals’ performance score on each measure, condition or procedure, domain-specific score, and each hospital’s total performance score on the Hospital Compare Web site.

Incentive Payments

Background: ACA requires the publication of the number of hospitals receiving VBP incentive payments, including the range and total amount of the payments, and the number of hospitals receiving less than the maximum incentive payment available and the range and amount of the payments.

CMS’ Proposal: CMS proposes to post aggregate hospital VBP information on the Hospital Compare Web site. CMS states, “*We will provide further details on reporting aggregated information in the future.*”

Data Review Process

Background: An additional ACA requirement is for hospitals to be provided with the opportunity to review and submit corrections to their information before it becomes public.

CMS’ Proposal: CMS proposes to use the same procedures adopted for the Hospital IQR program, in terms of reviewing and submitting corrections, for the VBP program. CMS proposes “*to make each hospital’s Hospital VBP performance measure score, condition-specific score, domain-specific score, and total performance score available on the hospital’s QualityNet account on November 1, 2012.*” CMS also proposes to provide hospitals with 30 calendar days to review and submit corrections to these scores.

X. RECONSIDERATION AND APPEALS PROCESS

Federal Register page 2484

Background: ACA requires the Secretary to establish a process whereby a hospital can appeal the calculation of its VBP performance assessment. ACA does not allow for an administrative or judicial review process relative to the methodologies selected by CMS for calculating the incentive pool, performance standards, performance period, performance scores, measure selection, or validation.

CMS' Proposal: For FFY 2013, CMS is **not** proposing an appeal process in this proposed rule. CMS does seek input from the provider field regarding recommendations for an agency level appeals process and recommended staff calculations for future rulemakings.

Addendum A

Glossary of Terms

Achievement Score—a hospital’s performance in the performance period compared to the national benchmark

Achievement Threshold—the 50th percentile of hospital performance on the applicable measure during the baseline period

Baseline Period—the data used to calculate individual hospital improvement and to set the national performance standards that will determine achievement scores.

Consistency Points—additional points (0-20) earned if the minimum percentile of all eight HCAHPS dimensions for a hospital is at or above the 50th percentile

Improvement Score—based on a hospital’s performance on each applicable measure during the specified performance period compared to the baseline period.

Performance Period—data are used to calculate an achievement score and the end point for an improvement score.

Addendum B

Acronyms

| | |
|--------|--|
| ACA | Affordable Care Act |
| AHRQ | Agency for Healthcare Research and Quality |
| AMI | Acute Myocardial Infarction |
| CMS | Centers for Medicare and Medicaid Services |
| DRA | Deficit Reduction Act |
| DRG | Diagnosis Related Groups |
| EHR | Electronic Health Records |
| FFY | Federal Fiscal Year |
| HAC | Hospital-Acquired Condition |
| HAI | Healthcare Associated Infections |
| HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems |
| HF | Heart Failure |
| IPPS | Inpatient Prospective Payment System |
| IQR | Inpatient Quality Reporting |
| MDH | Medicare Dependant Hospital |
| MMA | Medicare Prescription Drug, Improvement, and Modernization Act |
| PN | Pneumonia |
| PSI | Patient Safety Indicator |
| QIO | Quality Improvement Organization |
| SCH | Sole Community Hospital |
| SCIP | Surgical Care Improvement Project |
| VBP | Value-Based Purchasing |