The background of the top half of the image features a close-up of the American flag's stars and stripes. Overlaid on this is a white document with a stethoscope resting on it. The document has the text "Health Care Reform" printed on it.

Health Care Reform

# RACE TO VALUE

Health Care Reform Payments  
Simplified

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## Introduction

**M**ore than a year has passed since the Patient Protection and Affordable Care Act (ACA) was signed into law. A new health care vernacular now dominates the media as well as health care discussions at all levels. “Accountable Care Organizations (ACOs)”, “bundled payment”, “readmissions”, and “value-based purchasing (VBP)” are becoming increasingly commonplace terms. Being well-informed about ACA requirements, with all of their complexity, is the starting point to applying critical, “so what now” leadership thinking. Before hospital leaders can envision the future of their organizations, define potential strategic scenarios or begin the work essential to ensuring optimal success during the economic and health care transformations ahead, they must have a sound, fact-based, working understanding of the terms and provisions driven by the ACA.

The ACA has been characterized as the most significant social legislation since the enactment of Medicare in the mid-1960’s. In the rush and complexity of implementing the many ACA requirements, popular and common use of new terms in health care conversations too often assume an in-depth understanding of these provisions. Health care executives themselves are in the midst of trying to understand the transforming health care environment, are still educating their boards and the medical staffs, and are working to begin educating their front line staffs. Though most trustees are becoming increasingly familiar with the terms and have a general idea of their meaning, they often lack the detailed knowledge about these new concepts critical to making confident leadership decisions.

One of the primary objectives of health care reform’s new reimbursement/payment methods is to shift the nation’s health care delivery system from one that is paid based on volume (the number of services received/fee-for-service) to a payment system based on value (payment for high quality, cost-effective care). ACOs, bundled payments, readmission penalties, and VBP are among the payment methodologies to be implemented under the ACA. The Congressional Budget Office (CBO) projects a \$500 billion reduction in Medicare spending through these reform efforts. Beginning in 2010, annual Medicare market basket updates will be reduced, ultimately resulting in a \$157 billion payment decrease. From 2014-2019, another \$14 billion reduction will be realized, with a 75 percent reduction in payments to Medicare Disproportionate Share Hospitals (DSH). Hospitals may experience other

revenue reductions if they fail to prevent hospital readmissions or have a high incidence of hospital-acquired conditions.

The budget deficit reduction agreement also holds the risk of further reimbursement reductions for hospitals. The agreement establishes a bipartisan congressional committee, the “super committee”, tasked with recommending \$1.2-\$1.5 trillion in budget savings. If recommendations are not approved by Congress prior to December 31, 2011, Medicare provider payment cuts amounting to 2 percent over nine years (2013-2021) will be triggered.

The implications of these changes are critical to all hospitals. Despite the fact that rule-making and implementations are still in process and in flux, hospital leadership cannot afford to wait before developing strategic plans and actions in response to these changes. It is imperative that hospital trustees and others have the information and resources necessary to make well-informed, fact-based and confident decisions.

This document has been developed based on information available as of August 2011 to provide trustees and others with a clear, straightforward understanding of health care reform’s payment methodologies. As public comments are submitted, proposed rules debated and final rules issued, readers should be aware that some details and provisions are expected to change. Regardless, we hope *Race to Value* contributes to trustees’ knowledge of health care reform payment methodologies, and a greater understanding of its implications on their organizations.

## Accountable Care Organizations (ACOs)

### Quick Summary

ACOs are the much talked about new health care entity created by the ACA. An ACO is a group of providers and suppliers who agree to be accountable for achieving three aims:

- Better care for individuals;
- Better health for populations; and
- Lower growth in health care spending.

If successful in achieving pre-determined quality thresholds and benchmark savings, the ACO will be eligible for a share of the cost-savings. ACOs must also be willing to assume risk for potential losses.

### Inside ACOs: Q&A

#### **What is it?**

An Accountable Care Organization is a new type of health care entity created by the Patient Protection and Affordable Care Act (ACA). According to the U.S. Department of Health and Human Services (HHS), the ACO “agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending.”

*Source: Centers for Medicare & Medicaid Services. Medicare Fact Sheet: Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program. March 31, 2011.*

#### **Why do we need a new type of health care entity?**

The structure of an ACO is designed to provide seamless, high-quality, patient-centered care in an effort to achieve the aims of:

- Better care for individuals
- Better health for populations
- Lower growth in expenditures

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#### ***Who can be part of an ACO?***

The ACA and the proposed rules are flexible as to who may work together as an ACO. The ACA specifies that an ACO may include the following types of groups:

- Professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements
- Networks of individual practices of professionals
- Partnerships or joint ventures arrangements between hospitals and professionals
- Hospitals employing physicians and other clinical professionals
- Other Medicare providers and suppliers as determined by the Secretary

Critical access hospitals (CAHs) billing under method II are also eligible to form an ACO. CAHs not billing under method II, federally qualified health centers (FQHCs) and rural health clinics (RHC) may participate in ACOs, but may not independently form an ACO.

ACOs must have a shared-governance structure which includes providers, suppliers and Medicare beneficiaries. Under the proposed rule, at least 75% of the ACO governing board must be ACO providers, and each must have proportionate control. The rule also requires at least one board member be a Medicare beneficiary.

#### ***When do ACOs begin?***

This voluntary program begins January 1, 2012. ACOs must submit an application to participate, and there is no guarantee of acceptance. ACOs may continue to apply after the initial January 1, 2012 date. ACOs must agree to participate in the program for three years.

#### ***Why should a provider participate in an ACO?***

In addition to the benefit of providing high-quality, well-coordinated care to patients and improving the health of the population, if the ACO can demonstrate cost-savings by delivering high-quality care they will be eligible to share in those savings with the Center for Medicare and Medicaid Services (CMS).

#### ***How does it work?***

ACOs must choose to participate in one of two risk models:

- *One-sided model:* ACOs participate in shared savings only for the first two years, but must begin assuming risk for shared losses in the third year.
- *Two-sided model:* ACOs share in savings and risk for all three years.

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#### ***How does it work? (cont.)***

The one-sided model was designed to allow ACOs with less experience with risk, particularly smaller ACOs, to enter the program. ACOs that accept the two-sided model are eligible for a greater share in any savings.

To be eligible for a shared savings payment, an ACO must meet or exceed quality performance standards and achieve a pre-determined benchmark for savings.

If beneficiaries receive services from a FQHC or RHC the ACO may qualify for greater shared savings.

#### ***Do beneficiaries sign up for an ACO?***

Beneficiaries do not sign up with an ACO, and can seek services outside of the ACO. Medicare will retrospectively look at beneficiaries' use of services to determine if the ACO should be credited with cost-savings and improvement in care.

The ACO must notify beneficiaries that they are in an ACO at the time of service, allowing the beneficiary to continue with the services or seek services from another provider.

The ACO must also notify the beneficiary that claims data may be shared within the ACO, allowing beneficiaries to opt-out of the data sharing.

In the absence of beneficiary assignment, ACOs will receive monthly data reports from CMS on the services their beneficiary patients are receiving, allowing an estimation of performance.

#### ***How will CMS measure quality?***

To be eligible for shared savings, the ACO must meet or exceed 65 quality measures in five areas:

- Patient/caregiver experience of care
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health

CMS will score the measures on a linear scale and roll them up into five scores for each of the five areas. Each area will be weighted the same.

In year one (2012), ACOs will submit the data on the 65 measures. In following years, CMS will set benchmarks that must be achieved to qualify for shared savings payments. ACOs that significantly exceed benchmarks may receive a greater share of the savings.

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#### **What else?**

50% of the primary care physicians participating in an ACO must achieve information technology “meaningful use” status following the first year of an ACO’s participation in the shared savings program.

#### **What about the legal and regulatory barriers?**

In an effort to address the potential issues and barriers of antitrust, fraud, abuse and tax-exemption for ACOs, CMS, the Office of the Inspector General (OIG), the Federal Trade Commission (FTC), the Department of Justice (DOJ), and the IRS released notices and proposed policy statements to provide additional guidance for ACO participants.

### Critical Actions for Trustees

1. For general purposes, ensure a firm understanding of ACOs.
2. Whether participating in an ACO or not, consider how your organization contributes to and achieves the three objectives of ACOs (better care for individuals, better health for populations, and lower growth in expenditures) by delivering high-quality, patient-centered, and seamless care for patients.
3. Evaluate the potential for establishing your organization as an ACO, including in-depth and detailed analysis of all requirements, costs, risks and benefits.
4. Consider a competitor’s potential for establishing an ACO and the implications to your organization.

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4. Federal Register/Vol. 76, No. 67/Thursday, April 7, 2011/Proposed Rules.42 CFR Part 425, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations. www.gpo.gov. April 7, 2011.
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6. Federal Trade Commission. FTC, DOJ Seek Public Comment on Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations. www.ftc.gov. March 31, 2011.
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## Bundled Payments

### Quick Summary

A new, voluntary bundled payment program will be rolled out by CMS under the requirements of the Accountable Care Act (ACA). Originally scheduled to begin in January 2013, CMS has announced that it expects to release the rules sooner than expected. Designed to improve quality and control costs, bundled payment is one single payment for multiple services received by a patient from multiple providers during an “episode of care.” For this bundled payment pilot program, which is focused on hospital stays, an episode of care begins three days prior to admission and runs through the 30 days following discharge. Organized systems or hospitals, physicians and other providers participating in a bundled payment program agree contractually to work together to coordinate the patient’s care. They also agree on how the single payment – and financial risk – will be shared. Designed to integrate care, the pilot will begin by covering ten conditions and services to be selected by HHS.

### Inside Bundled Payments: Q&A

#### ***What is it?***

The Accountable Care Act (ACA) requires a National Pilot Program on Payment Bundling in Medicare.

Bundled payment is one payment for multiple services received by a patient from multiple providers during an “episode of care.”

For this pilot, it’s one payment built around a hospital stay that is designed to get providers to better coordinate care, manage costs and deliver quality.

#### ***When does it start?***

Per the ACA, the **voluntary** program is to start by January, 2013 and continue for five years. If the program is successful in improving quality and controlling costs, the HHS secretary has the authority to expand the program.

CMS has indicated they will release the rules sooner than expected, and will focus on acute and post-acute care.

#### ***What is an “episode of care?”***

It’s the time period that: 1) starts three days before a hospital admission; 2) includes the hospital stay; and 3) includes the 30 days following discharge.

#### ***Who gets the payment?***

Payment could be made to an organization of providers (e.g., a hospital, physicians, post-acute care providers) or a hospital or physician group that establishes contracts with the other providers to work together and share payment and risk.

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#### ***What does the program cover?***

Ten conditions will be selected by HHS.

Designed to integrate care, services may be provided by:

- Acute inpatient hospitals
- Physician services in and out of hospitals
- Outpatient hospitals
- Emergency rooms
- Post-acute services (home health, skilled nursing, inpatient rehabilitation, long-term care hospitals)
- Others that may be identified by Health and Human Services (HHS)
- Hospital and medical staff alignment and collaboration
- Shared information and data (electronic health records)
- Infrastructure to manage and disburse payments

#### ***What factors will be most critical to success in participating in a bundled payment arrangement?***

### **Critical Actions for Trustees**

#### ***Evaluate if you have what it will take...***

1. How strong is your hospital/medical staff alignment? Are you well integrated? Do you have or can you establish the organizational or contractual relationships needed to coordinate care across required services?
2. Can you communicate well with your other contracted providers? Do you have well-established electronic health records, good data and the strength of collaboration necessary to succeed?
3. Are you willing and able to assume and manage risk?
4. Can you align and manage incentives?
5. Are you willing and able to assume responsibility for the costs and quality of services that other providers deliver?
6. Do you have the infrastructure to manage and disburse (or accept) payments?

### **Sources**

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## Healthcare-Associated Conditions and Present on Admission Indicator Reporting

### Quick Summary

The Deficit Reduction Act of 2005 required payment adjustments to be implemented for certain healthcare-associated conditions (HCACs). For discharges beginning of or after October 1, 2008, CMS stopped paying for certain HCACs. To identify applicable conditions, hospitals are required to report “present on admission” (POA) information on diagnoses for discharges on or after October 1, 2007. In April, 2011, CMS began to publish hospitals’ HCAC performance publically, and are proposing to add new conditions to the list for non-payment.

CMS also issued the final rules implementing non-payment of federal dollars to Medicaid programs for healthcare-associated conditions. The implementation essentially extends Medicare HCAC provisions to Medicaid programs. The rule is broader than Medicare though. States may add other conditions for non-payment, as long as implementation doesn’t result in a loss of access to care or services for Medicaid beneficiaries.

### Inside the HCACs & POAs: Q&A

#### ***What are they?***

A healthcare-associated condition (HCAC) is a condition that an individual “acquires,” or that results from a hospitalization, that are presumed to be reasonably preventable.

Present on Admission (POA) indicates which diagnoses were present at the time an order for inpatient admission occurs.

#### ***When is this effective?***

For Medicare, in 2008 CMS stopped paying for healthcare-associated conditions. Beginning April, 2011, CMS added a link to the Hospital Compare Web site to enable downloading of HCAC performance measures.

#### ***How are HCACs determined?***

The HHS Secretary determines the inclusion of specific HCACs based on the criteria that the HCAC is:

- High cost, high volume or both
- The cause for a higher paying DRG (Diagnosis Related Group) when present as a secondary diagnosis
- Reasonably preventable using evidence-based guidelines

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#### **What HCACs are made public?**

The following eight HCACs are publicized:

- Objects Accidentally Left in the Body After Surgery (Foreign Object Retained After Surgery)
- Air Bubble in the Blood Stream (Air Embolism)
- Mismatched Blood Types (Blood Incompatibility)
- Severe Pressure Sores (Pressure Ulcer Stages III & IV)
- Falls and Injuries (Falls and Trauma (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)
- Vascular Catheter-Associated Infection
- Catheter-Associated Urinary Tract Infection (UTI)
- Signs of Uncontrolled Blood Sugar (Manifestations of Poor Glycemic Control)

*Source: Hospital Compare. [www.hospitalcompare.hhs.gov/staticpages/help/hospital-glossary.aspx?Choice=H](http://www.hospitalcompare.hhs.gov/staticpages/help/hospital-glossary.aspx?Choice=H)*

CMS also does not pay for the following additional HCACs:

- Surgical site infection following Coronary Artery Bypass Graft (CABG), certain orthopedic procedures or bariatric surgery for obesity
- Deep vein thrombosis/pulmonary embolism following total knee or hip replacements

#### **What's next?**

For FY 2012, CMS proposes to add contrast-induced acute kidney injury to the HCAC categories currently not recognized for payment.

CMS also proposes to add to the diagnoses list five new diagnosis codes in three HCAC categories.

In 2015, under the ACA, Medicare payments (base DRGs) to hospitals in the top quartile for HCACs will be reduced by 1%. This will apply to all Medicare discharges.

#### **Are all hospitals included?**

HCAC payment requirements presently only apply to Inpatient Prospective Payment Systems (IPPS) Hospitals. Critical Access Hospitals (CAHs) and specified other facilities are exempt.

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#### ***How is Medicaid different?***

For Medicaid, the rule prohibiting federal payments to state Medicaid programs for HCACs is effective July 1, 2011, but will not be enforced until July 1, 2012.

#### ***Are the HCACs the same under Medicaid?***

State Medicaid payments are prohibited for Provider-Preventable Conditions (PPCs). PPCs include HCACs and Other Provider-Preventable Conditions (OPPCs).

Medicaid HCACs apply to inpatient hospital settings and include the full list of Medicare HCACs with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement in pediatric and obstetric patients.

OPPCs are conditions applicable in any healthcare setting and include the three specified Medicare nonpayment National Coverage Determinations (NDCs) for erroneous procedures (the wrong procedure is performed, the correct procedure is performed on the wrong body part, or the correct procedure is performed on the wrong patient.)

States may deny payment for additional OPPCs with CMS approval if they are found to be reasonably preventable via evidence-based guidelines, have a negative consequence for the beneficiary and are auditable.

### **Critical Actions for Trustees**

1. Examine, review and understand your hospital's data on Hospital Compare.
2. Understand the HCAC information provided on Hospital Compare and its implications.
3. Understand your state's rules for non-payment of HCACs.
4. Determine how your hospital compares to your competitors and your peers, and how your performance impacts your revenues.
5. Approve quality improvement plans as required, and monitor your hospital's progress and performance.
6. CMS makes HCAC data available to hospitals prior to posting; ensure it is previewed annually for accuracy.
7. Review releases of proposed and final rules regarding Medicare payment reduction to hospitals for HCACs in 2015.

### Health Care Reform Payments Simplified

#### Sources

1. Centers for Medicare & Medicaid Services' Fact Sheet: CMS Reports Rates of Hospital Acquired Conditions in America's Hospitals. [www.cms.gov](http://www.cms.gov). April 6, 2011.
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## Readmission Reduction Program

### Quick Summary

Beginning in FY 2013, CMS will reduce its payments to hospitals with “high rates” of readmissions in an effort to improve quality and reduce costs. Whether a hospital’s payment is cut depends on how well the hospital controls its preventable readmissions.

The reduction, which will apply across all discharges, is limited to 1% in 2013, 2% in 2014 and 3% in 2015 and thereafter.

### Inside the Readmission Reduction Program: Q&A

#### ***What is the Readmission Reduction Program?***

As an incentive to get hospitals to improve quality and reduce costs, CMS will cut payments to hospitals with high rates of so-called preventable readmissions.

CMS is proposing its rules in two parts. In 2011, for fiscal year (FY) 2012 CMS has proposed:

- The conditions the readmissions rules apply to
- A definition of readmission
- The measures and methods for measuring
- Public reporting

In 2012 for FY2013 CMS will propose the rules for adjusting payments and applicable hospitals.

#### ***What is a “readmission”?***

A patient’s return to an acute care hospital within 30 days after discharge to a non-acute setting (home, skilled nursing, rehabilitation, etc.)

#### ***What “conditions” does the program apply to?***

Readmissions are counted following discharge for three conditions:

- Acute Myocardial Infarction (AMI) (heart attack)
- Heart Failure
- Pneumonia

#### ***What’s excluded?***

Transfers to another hospital and planned readmissions are excluded.

An individual readmitted twice is only counted once. Otherwise, all readmissions are included, regardless of the principal diagnosis.

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#### **Why are all readmissions counted?**

CMS's reasons for including all readmissions regardless of principal diagnosis:

- From the patients' perspective, readmission for any reason is adverse, and CMS wants its measures to be patient-centered
- Limiting readmissions to a diagnosis allows "gaming" by changing coding practices or avoiding patients with conditions that are part of readmission measures
- There is no clinical/technically sound way to identify readmissions that are unrelated, and hospitals should strive to reduce all readmissions from all causes

#### **Are all hospitals included?**

Critical access hospitals and post-acute care providers, and hospitals with small numbers of patient cases (CMS is proposing 25 discharges for each of the three measures) are excluded.

#### **When does this take effect?**

The payment adjustment (reduction) will start in fiscal year (FY) 2013.

#### **What will it cost?**

If a hospital has more readmissions than expected, it must repay Medicare. CMS will determine at a later date the adjustment factor that will decrease the hospital's payment for **all** discharges. In FY 2013, the reduction is limited to 1%, in 2014 it's 2%, and in 2015 and thereafter the limit is 3%.

#### **What else?**

Hospitals with high readmission rates may participate in a voluntary program with a patient-safety organization (PSO), and will need to implement improvement plans.

"PSOs are organizations that share the goal of improving the quality and safety of health care delivery. Organizations that are eligible to become PSOs include public or private entities, profit or not-for-profit entities, provider entities such as hospital chains, and other entities that establish special components to serve as PSOs." *Source: The Agency for Healthcare Research and Quality. [www.pso.ahrq.gov/psos/overview.htm](http://www.pso.ahrq.gov/psos/overview.htm)*

CMS may add more conditions in FY 2015, including chronic obstructive pulmonary disorder (COPD), and cardiac and vascular surgical procedures.

#### **What about public reporting?**

CMS is proposing a similar reporting process and timeframes to the current reporting on Hospital Compare.

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#### Critical Actions for Trustees

1. Understand the information provided about the readmission reduction program.
2. Ask your hospital's leadership (CEO, CFO) to evaluate how the readmission reduction program may impact your organization's revenues.
3. Monitor your hospital's readmission rates and ensure that quality improvement plans are in place to minimize or eliminate readmissions.
4. CMS will make readmission data available to hospitals prior to posting on Hospital Compare; ensure it is previewed annually for accuracy, and to determine potential implications.
5. Monitor release of additional proposed and final rules regarding the Medicare readmission reduction program.

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## Value-Based Purchasing (VBP)

### Quick Summary

CMS will withhold a percentage of Inpatient Prospective Payment System (IPPS) hospital operating payments beginning FY2013 at 1% and increasing annually up to 2% in 2017 (estimated to be \$850 million for FY2013). Hospitals have a chance to earn some or all of this money back, either by achieving certain high-level quality scores or, if a hospital's performance is not at achievement levels yet, by improving its quality performance. CMS will score 12 clinical measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance to determine how much, if any, of that \$850 million a hospital may receive. The clinical scores will account for 70% of a hospital's total score, and the HCAHPS scores will account for 30%. The scores will also appear on Hospital Compare ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)).

### Inside the VBP Concept: Q&A

#### ***What is value-based purchasing (VBP)?***

VBP is payment for actual performance vs. payment for just reporting hospital performance. With reporting, the Medicare payment is the same whether the hospital's performance is good or bad. Under VBP, CMS will keep 1-2% of hospitals' payments – and hospitals will have a chance to earn it back depending on how good their quality of care is.

#### ***How is "quality performance" defined?***

Quality performance is defined by 12 clinical measures:

- 2 for heart attack
- 1 for heart failure
- 2 for pneumonia
- 7 for surgical care
- **and** a hospital's HCAHPS scores

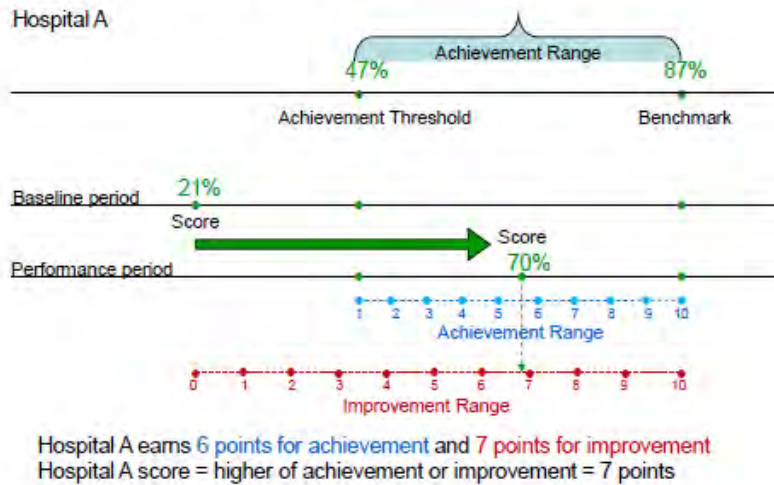
HCAHPS is Hospital Consumer Assessment of Healthcare Providers and Systems - in other words, it's a patient satisfaction survey.

#### ***How is it measured?***

For each measure, a hospital's performance will be scored in two ways - achievement and improvement. CMS will use whichever score is best.

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Figure 1: Sample VBP Scoring for a Measure



(Source: AHA Regulatory Advisory, Hospital Value-Based Purchasing Program: The Final Rule, May 24, 2011.)

**How will “achievement” be measured?**

Minimum achievement threshold – a hospital must get at least to this point to earn any points.

Benchmark achievement threshold – anything above this point gets maximum points.

Scoring:

- Less than the minimum threshold – 0 points
- Between the minimum threshold and the benchmark 1-9 points
- At or above the benchmark – 10 points

**How will “improvement” be measured?**

Baseline period – a hospital’s baseline is how well the hospital did on the quality measures from July 1, 2009 to March 31, 2010.

Performance period – the time to improve, measured July 1, 2011 to March 31, 2012.

If a hospital improves, it earns points (which will translate into money).

**How is HCAHPS performance scored?**

It’s measured in the same way, using the dimensions now found on Hospital Compare, and measuring “top-box” (“best category”) scores. (That is, did the patient check the box at the top of survey responses – the one that indicates the hospital’s best performance?).

Two exceptions, “cleanliness” and “quietness” are combined into one measure and “recommend the hospital” is excluded.

CMS will also measure how consistent hospitals’ HCAHPS scores are.

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#### ***Then what?***

CMS adds up all the scores for the clinical measures and the HCAHPS dimensions. Clinical scores will be worth 70% of the hospital's overall score and HCAHPS scores will be worth 30%. Scores will be published on Hospital Compare.

#### ***Where's the money coming from?***

From hospitals. Beginning FY2013, CMS will withhold 1% of all Inpatient Prospective Payment System (IPPS) operating payments, estimated to be \$850 million dollars for all participating hospitals. The withhold percentage will go up .25% annually until it reaches 2% in 2017. How well a hospital scores will determine how much, if any, of that money the hospital will get back.

#### ***What's next?***

CMS will release more information in 2012 regarding inclusion of efficiency measures, how well hospitals manage costs, measured as the cost per Medicare beneficiary, in the program.

Critical Access Hospitals (CAHs) are not included in this VBP program; however the ACA calls for HHS to develop a VBP demonstration program for CAHs in the future.

### Critical Actions for Trustees

1. Understand how VBP applies to your organization. Some hospitals, including Critical Access Hospitals (CAH) and those with small numbers of patient cases or measures, are excluded now but may be included in the future.
2. Know and evaluate your hospital's performance scores.
  - a. What was your baseline performance in 2009 (July 1, 2009 to March 31, 2010)?
  - b. What are your performance period scores?
  - c. Have your scores improved? Declined? Will they be good enough to earn back your withhold money?
3. Use the current Inpatient Quality Reporting (IQR) program to evaluate your organization's performance. How do you compare to your peers? Where should your scores be to compete for VBP payment? What improvement plans should be implemented? Monitor your progress towards achieving and/or maintaining target scores.
4. Should you expect a loss or the possibility of earning back some of your withhold? Use AHA's VBP calculator to estimate your scores and their effect on your payment ([www.aha.org/VBPcalc](http://www.aha.org/VBPcalc)).

### Sources

1. Department of Health and Human Services. Federal Register/Vol. 76, No. 87/ Thursday, May 5, 2011/Proposed Rules. Medicare Program, Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment system and Fiscal Year 2012 Rates.
2. American Hospital Association. Regulatory Advisory, Hospital Value-Based Purchasing Program: The Final Rule. May 24, 2011.
3. Guilford-Blake, Roxanna. Winners and Losers Under VBP. HealthLeaders Media. July 13, 2011. [www.healthleadersmedia.com](http://www.healthleadersmedia.com).

## Glossaries

Glossaries of health care terms are available at:

- U.S. Department of Health and Human Services. [www.healthcare.gov/glossary/04262011a.pdf](http://www.healthcare.gov/glossary/04262011a.pdf).
- The Henry J. Kaiser Family Foundation, Focus on Health Reform. [www.kff.org/healthreform/upload/7909.pdf](http://www.kff.org/healthreform/upload/7909.pdf).
- WebMD. [www.webmd.com/a-to-z-guides/health-care-reform-glossary](http://www.webmd.com/a-to-z-guides/health-care-reform-glossary).



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