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HEALTH CARE

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IN PROPOSED RULE FOR HOSPITAL INPATIENT VALUE-BASED PURCHASING PROGRAM, CMS MOVES ONE STEP CLOSER TO PAYMENT BASED ON PERFORMANCE, AND INCREASES ACCESS TO DATA FROM QUALITY IMPROVEMENT ORGANIZATIONS

On January 13, 2011, the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid (CMS) published a proposed rule that, if finalized in its current form, will affect the way in which hospitals are reimbursed for services provided to Medicare beneficiaries. Specifically, the rule will further develop a system of hospital reimbursements that is partially based on quality rather than on quantity (i.e., volume of services provided). In addition, the proposed rule addresses the CMS' ability to access data from Quality Improvement Organizations (QIOs).

The Hospital Inpatient Value-Based Purchasing Program ("VBP Program") is one of the many regulatory changes established by the Patient Protection and Affordable Care Act, which was signed into law on March 23, 2010 and amended by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010 (collectively known as the "Affordable Care Act").

Section 3001(a) of the Affordable Care Act gave rise to Section 1886(o) of the Social Security Act, which directs the Secretary to establish a "hospital value-based purchasing program" under which "value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards" for "the performance period for such fiscal year." The incentive payments for the fiscal year 2013 are to be funded through a reduction to fiscal year 2013 base operating Diagnosis Related Group (DRG) payments for each discharge of 1%, as required under Section 1886(o)(7).

The proposed rule is one of CMS' steps toward implementing Section 1886(o) of the Social Security Act. If finalized, the proposed rule's effect on hospitals would be felt almost immediately. While the rule would provide for potential incentives to be made on or after October 1, 2012,[1] certain incentives would actually be based on performance measurements during a period beginning on July 2011.

It is important to understand the proposed rule in the context of CMS' other recent regulatory changes. In the past several years, there has been a push by CMS to find ways to reimburse providers based on the quality of services provided, away from a "fee-for-service" model to one that is based more on "pay-for-performance."[2]As noted in the preamble to the proposed rule, CMS "promotes higher quality and more efficient health care," and wants to move toward rewarding "value, outcomes, and innovations instead of merely volume." In recent years, CMS has undertaken initiatives to lay the foundation for rewarding providers and suppliers based on quality of care, by tying a portion of reimbursement to performance on quality measures. The agency's goal is to make Medicare into an "active purchaser of quality healthcare," instead of merely a "passive payer."

One of CMS' previous initiatives, Medicare Hospital Inpatient Quality Reporting Program ("Hospital IQR Program"), put in place an extensive hospital quality reporting mechanism. The program provides for payment reductions to hospitals that do not submit data on certain quality measures.

Under the Hospital IQR Program, 45 measures were adopted for the fiscal year 2011 payment determination. These measures were made available to the public primarily through *Hospital Compare* (www.hospitalcompare.hhs.gov), an interactive HHS Website, in which patients (or potential patients) could compare hospitals based on these measurements. Quality measurement data that was not suitable for *Hospital Compare* was made available to the public through other means.

In its proposed rule, CMS is building on the Hospital IQR Program by not only requiring quality measurement reports, but also actually rewarding hospitals based on the data reported.

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[1] Not all hospitals are eligible for incentives. The preamble to the proposed rule states as follows:

> Section 1886(o)(1)(C) provides that the Hospital VBP program applies to subsection (d) hospitals (as defined in section 1886(d)(1)(B)), but excludes from the definition of the term "hospital," with respect to a fiscal year: 1) a hospital that is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) for such fiscal year; 2) a hospital for which, during the performance period for the fiscal year, the Secretary cited deficiencies that pose immediate jeopardy to the health and safety of patients; and 3) a hospital for which there is not a minimum number (as determined by the Secretary) of applicable measures for the performance period for the fiscal year involved, or for which there is not a minimum number (as determined by the Secretary) of cases for the applicable measures for the performance period for such fiscal year.

[2] This sentiment has also been reflected in academia. *See* Porter, M.E. & Teisberg, E.O. "Redefining Health Care: Creating Value-Based Competition On Results," Harvard Business School Press, 2006.

Of the 45 measures under the Hospital IQR Program, the VBP Program would adopt 18 for the fiscal year of 2013 (which begins October 1, 2012). 17 of those measures would be related to "clinical process of care," while one additional measure, the HCAHPS survey,[3] would be related to "patient experience of care." For fiscal year 2014, the VBP Program would add three outcome measures.

CMS sets forth a proposed methodology for assessing the total performance of each hospital based on "achievement" and "improvement" ranges for each applicable measure. Furthermore, CMS proposes to calculate a "total performance score" by combining the results of this information,[4] assigning different weights for measures regarding clinical process of care (70 percent) and those for patient experience of care (30 percent). This total performance score would then be converted into a value-based incentive payment, by the use of a linear exchange function.

For clinical process of care and HCAHPS measures, the performance period for fiscal year 2013 payment determinations would run for a three–quarter performance period, from July 2011 through March 2012. In order to determine whether hospitals meet the proposed performance standards for these measures, performance during the proposed performance period would be compared to their performance during a proposed three-quarter baseline period running from July 1, 2009, through March 31, 2010.

In the preamble to the proposed rule, CMS also provides an explanation of how it came to choose the specific 18 measures out of the 45 adopted by the Hospital IQR Program. While some measures were included because they were mandated by statute, under Section 1886(o)(2) of the Social Security Act,[5] other measures were excluded also because Section 1886(o)(2) provides that the Secretary may not select a measure unless included on the *Hospital Compare* website for at least a year.

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[3] "The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care." *See HCAHPS Fact Sheet 2010. Available at* http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%202010.pdf

[4] The total performance score would be obtained "by combining the greater of the hospital's achievement or improvement points for each measure to determine a score for each domain."

[5] Section 1886(o)(2)of the Social Security Act requires that measures for the value-based incentive payments for fiscal year 2013 include the following:

- Acute myocardial infarction (AMI).
- Heart failure.
- Pneumonia.
- Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as "Surgical Infection Prevention" for discharges occurring before July 2006).
- Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.
- HCAHPS — Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

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It is important to be aware that the number of measures used under the VBP Program will likely increase in subsequent years. In the preamble to the proposed rule, CMS emphasizes the great need to act "with all speed and deliberateness" to get additional measures included under the Hospital VBP Program, because of evidence in two federal reports that "tens of thousands of patients do not receive safe care in the nation's hospitals."[6]

Because of this great need, the agency proposes that once certain measures have been displayed for a full year on *Hospital Compare*, they should be effective immediately, without the requirement of further notice and comment rulemaking.

In addition, in the preamble to the proposed rule, CMS discusses in detail the applicability of the VBP Program to certain hospitals, hospital notification and review, reconsideration and appeal, and validation under the program for fiscal year 2013.

CMS also discusses how it will monitor and evaluate how the VBP Program is implemented, and how the program will affect access and quality of care provided. CMS further notes that it has worked with other entities to explore how Electronic Health Records (EHRs) can assist in minimizing the resources necessary for quality reporting.

Finally, CMS discusses the issue of QIO Quality Data Access, and how past regulations have imposed significant restrictions on a QIO's ability to disclose its information, in particular information related to Quality Review Study (QRS). According to CMS, the current regulations impose stringent restrictions on a QIO's ability to disclose information to CMS itself.

CMS cites various reasons why the restrictions on access to QIO data are no longer applicable. For example, CMS mentions technological advances since 1985, several laws protecting sensitive information such as HIPAA and FISMA, the current use by QIOs of CMS claims data, as well as the change of the QIOs' functions. CMS also cites the need to better manage the QIOs themselves, including the need for improved CMS oversight of QIO physician reviewers.

Based on the above, CMS proposes several changes to the regulations governing QIOs including:

- Amending the definition of the QIO review system to include CMS.
- Modifying a section of the regulations "to clarify the Department's general right to access non-QRS confidential information."
- Removing limitations to CMS' access to information regarding the QIO's internal deliberation.
- Eliminating restrictions to CMS' access to QRS data, which is currently limited to "onsite" information only.

CMS notes that increased access to QIO information is vital to performance-based incentive payment programs, and welcomes comments on the disclosure of QIO data to researchers as well.

[6] The two reports cited are the following: 1) OEI-06-09-00090 "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries." Department of Health and Human Services, Office of Inspector General, November 2010; and 2) 2009 National Healthcare Quality Report, pp. 107-122. "Patient Safety," Agency for Healthcare Research and Quality.

If the proposed rule is finalized, while payments for hospital services provided will still remain linked primarily to volume of service, the implementation of the VBP Program will be an important step in the incremental transformation of the CMS' reimbursement system. Just as the VBP Program builds on the reporting system put in place Hospital IQR Program, providers and suppliers may reasonably expect future CMS initiatives to build on the VBP program itself. CMS will continue to gather data from QIOs, hospitals, and other sources that will further enhance its understanding of which areas of the healthcare system need further regulatory intervention. In addition, healthcare reform is still very much at the forefront of political debate. Therefore, more future changes are likely to follow.

Comments to the proposed rule must be made no later than 5pm, March 8, 2011.

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JONES WALKER PRESENTS
HEALTH CARE SEMINAR AND WEBINAR

Jones Walker will present "**Unnecessary Readmissions—Legal Implications & Prevention Measures**," a health care webinar **April 5, 2011**, from Noon-1:30 p.m. EDT. Featured speakers Jones Walker attorney Myla R. Reizen and Carol Boston-Fleischauer, consultant to the Advisory Board Company, will cover the importance of unnecessary readmissions and will provide 17 best practices for adopting a principled approach to reducing avoidable rehospitalizations.

In addition, Jones Walker will present "**Health Care Legislation Update—Accountable Care, Medical Home, and Key Trends**" a health care seminar **May 26, 2011**. The seminar will be held in Florida beginning at 8:30 a.m. EDT. Jones Walker attorneys David G. Radlauer, Rudolph R. Ramelli, Lynn M. Barrett, and Myla R. Reizen will be presenting. Other speakers include Fred Bayon of the Advisory Board Company and Tim Renjilian of FTI Consulting.

For more information on either the seminar or the webinar, or to register for either of these programs, please contact Courtney Farley at 504.582.8121, or e-mail her directly by clicking here.

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