Medicare to Roll Out Value-Based Purchasing Scorecards in July

Hospital Payments Will Depend on Performance in Fiscal Year 2013

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Medicare is on the cusp of announcing the rules of the road for its value-based purchasing (VBP) incentive payments, which will become effective in fiscal year 2013 (beginning on October 1, 2012). However, the Centers for Medicare and Medicaid Services (CMS) will begin computing scores on July 1, 2011, for the nation’s 3,800 hospitals that receive Medicare payments (minus a few categories of hospitals, such as critical-access facilities).

Mandated by the Patient Protection and Affordable Care Act (PPACA), the health care reform bill passed last year by Congress, the plan is an “incentive,” in the same way that a mother might threaten to deny her children nightly cookies if they don’t do their homework. In fact, the Medicare VBP is even more punitive than that: all 3,800 hospitals will lose 1% of their Medicare reimbursement in fiscal year 2013, and those funds will create a bonus pool of approximately $1 billion. Only the highest scorers will receive 1% back as an incentive payment, and they might not receive any more than that. Lower-performing hospitals will definitely not get their 1% back—hence the irony of calling this an incentive program.

Which facilities will receive how much for what score has not yet been determined. On January 13, 2011, the CMS issued a proposed rule that did not address the bonus pool redistribution formula, which is based on an arcane algorithm called a linear exchange function.

Gunter Wessels, a partner and health care practice principal based in Tucson at Total Innovation Group (with headquarters in Tampa) calls the algorithm “funny money magic math.” The purpose is to maintain an incentive for the best-performing hospitals (which are already doing about as well as anyone could hope, with little room for improvement expected) and to offer some money to the laggards so that they don’t simply throw in the towel.

Medicare plans to use hospital quality data from its Hospital Compare database for the nine-month period starting July 1, 2011, to determine the size of the payments that will be doled out beginning on October 1, 2012. Hospitals have been sending data to the Hospital Compare database since November 2003. The number of measures that Medicare has had to report on has increased from 10 initially to 45 in fiscal year 2011 (the current year).

The VBP program is a whole other order of magnitude. Hospitals are losing 1% of the their total inpatient revenue from Medicare, not just a 2% decrease in any annual market basket increase—a ding to an otherwise small inflation adjustment, which is what hospitals lose when they do not report to Hospital Compare. The failure to recoup that 1% loss would be a big blow to most hospitals. Undoubtedly, hospitals that are in the top tier of VBP scores will get that 1% back, although the CMS has not yet announced this. The final rule will clarify that.

Scores will be based on how hospitals perform on 25 of the 45 Hospital Compare reporting measures. The 25 measures comprise 17 clinical process-of-care measures and eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

The 17 clinical measures include the hospital’s treatment of patients with acute myocardial infarction, heart failure, pneumonia, and health care–associated infections (HAIs) as well as individuals undergoing surgery. For example, in the case of one HAI measure, did the patient receive a prophylactic antibiotic within one hour before the surgical incision was performed? Some of the 17 measures also involve medication administration and discharge instructions, which are often numerous.

Drugs will play an even larger role in the eight HCAHPS measures. These include pain management, communications about medications, and discharge from the facility.

The problem with the VBP program is that hospitals that are bottom-tier performers are going to have to spend considerable dollars to improve their scores. But will they want to?

William O. Cleverley, PhD, President of Cleverley & Associates in Worthington, Ohio, has tweaked the data on hospital costs and their yield in terms of improved quality. He says that hospitals that improve the quality of their care, ironically, will also see a spike in costs.

“This finding implies that hospitals might face a trade-off between increased payments resulting from higher quality scores and increased costs necessary to reach those levels,” he said.

He noted a clearer relationship between improved mortality rates (which the CMS will add to the scoring system for fiscal year 2014) and reduced hospital costs. Even so, he admits that the relationship was clear with only some of the Medicare severity-adjusted Diagnosis-Related Groups that he used as yardsticks.

Private payers will undoubtedly be watching the Medicare VBP incentive program closely, and no one will be surprised if the CMS follows suit. The indications are that many hospitals, based on current managed care data, will score poorly.

VHA Inc., a health care alliance based in Irving, Texas, calculated that the national median VBP score was 53; however, hospitals will probably need scores higher than 70 to maximize their Medicare reimbursements. If VHA’s calculations are correct, a lot of hospitals will have to improve their quality, and fast, or suffer the consequences.