



Value-Based Purchasing

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Value-Based Purchasing

- History
- Plans for implementation
- Proposed Methodology
- CHA DataSuite VBP Report



History of Value-Based Purchasing

- Deficit Reduction Act of 2005 authorized CMS to develop a plan to implement a pay-for-performance or Value-Based Purchasing (VBP) Program for Medicare services provided by hospitals paid under IPPS
- *CMS' Report to Congress*
 - Options for plan implementation that builds on Medicare's current Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.
 - Recommended replacing the current quality-reporting program with one that would include public reporting and financial incentives to drive improvements in clinical quality, patient centeredness and efficiency.



Value-Based Purchasing Plans for Implementation

- Phased approach allowing time to gather baseline performance data for improvement scores, establish benchmarks and thresholds for computing attainment scores.
- Congress is currently reviewing various legislation that would implement VBP



Value-Based Purchasing Proposed Methodology

- Scoring will be based upon the data reported by hospitals in three quality domains:
 - Clinical process of care
 - Patients' perspectives of care
 - Outcomes
- The pool of incentive money would be funded via a carve-out from all hospital inpatient payments (2% to 5%)
- Redistribution of pool dollars will be dependent upon hospitals' scores



Value-Based Purchasing Proposed Methodology (continued)

- RHQDAPU process of care data have been publicly available on the CMS Hospital Compare site
- HCAHPS Patients' Perspectives of Care survey is required as part of pay for reporting as of FFY 2008
- HCAHPS data have been publicly reported since March 2008
- Two outcomes measures, 20-day mortality of patients with AMI or heart failure, have been publicly reported since June 2007



Value-Based Purchasing Proposed Methodology (continued)

- Overall hospital performance will be measured based on aggregate of the scores in all three domains
- RHQDAPU and HCAHPS Indicators
 - Each indicator receives a score between 1 and 10
 - Each indicator score is the higher of two measures – attainment or improved
- The attainment score for an indicator is determined by comparing the hospital's performance to national Benchmark and threshold levels for the indicator
 - The benchmark is the high performance measurement
 - The threshold is the minimum acceptable performance measurement



Value-Based Purchasing Proposed Methodology (continued)

- The improvement score for an indicator is determined by comparing the hospital's performance to its own prior year performance
- HCAHPS scoring will include a score (between 0 and 20) for achieving minimum performance across all HCAHPS indicators
 - If all eight of a hospital's HCAHPS indicator scores were above their respective 50th percentile (median) value, the hospital would receive the full 20 points
 - Otherwise, the minimum performance score would be based upon the indicator with the lowest percentile score and points awarded based upon how close that percentile rank is to the median



Value-Based Purchasing Proposed Methodology (continued)

- Each domain's performance scores are aggregated as a percentage of the maximum possible score, then the domain aggregates are combined to arrive at one overall VBP Total Performance Score
- Combining individual scores into one aggregate percentage allows CMS to compare hospitals on one standardized measure
- Scores will be calculated at the start of each IPPS payment year
- Overall scores from each of the three domains will be averaged together
 - Process measures will receive the highest weight
 - Current proposal: 70% Process, 30% HCAHPS



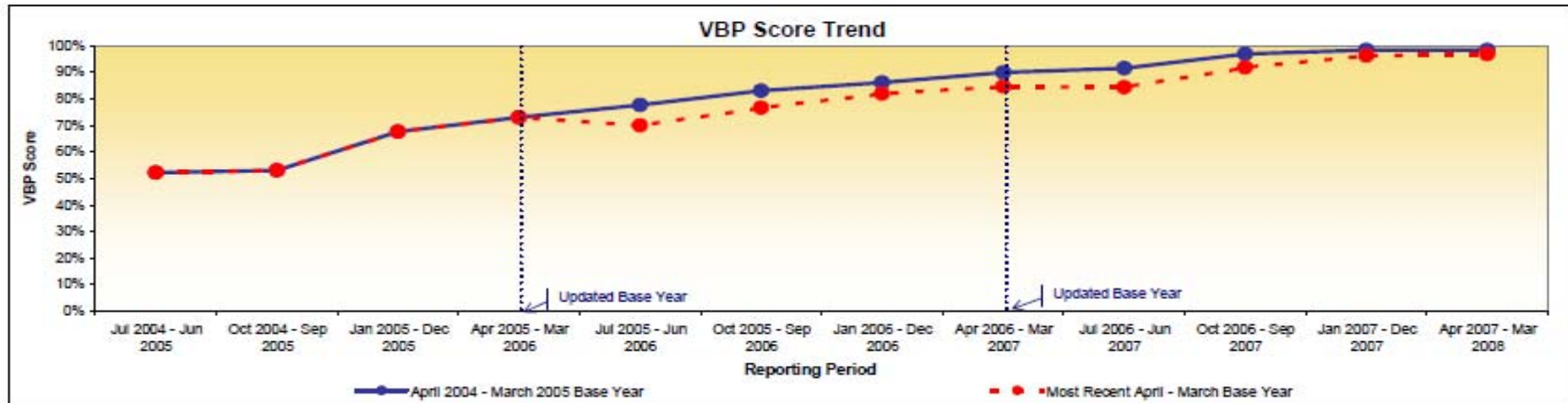
Heart Attack Patients Given Beta Blocker at Discharge	90.0%	80.0%	164	100%	167	99%	10	Does Not Apply	10
Heart Attack Patients Given Smoking Cessation Advice/Counseling	90.0%	80.0%	40	100%	38	100%	10	Does Not Apply	10
Heart Attack Patients Given Fibrinolytic Medication Within 30 Minutes Of Arrival	85.4%	53.0%	22	82%	17	94%	10	Does Not Apply	10
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	99.5%	87.0%	84	80%	81	99%	10	Does Not Apply	10
Heart Failure Patients Given Discharge Instructions	97.7%	72.0%	219	93%	163	96%	9	6	9
Heart Failure Patients Given Smoking Cessation Advice/Counseling	90.0%	80.0%	33	100%	28	100%	10	Does Not Apply	10
Pneumonia Patients Assessed and Given Pneumococcal Vaccination	97.6%	80.0%	134	88%	146	99%	10	Does Not Apply	10
Pneumonia Patients Given Smoking Cessation Advice/Counseling	90.0%	80.0%	37	100%	29	100%	10	Does Not Apply	10
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)	97.1%	87.0%	78	90%	101	96%	9	8	9
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics	90.0%	80.0%	114	89%	134	97%	10	Does Not Apply	10
Pneumonia Patients Assessed and Given Influenza Vaccination	99.1%	82.0%	41	90%	93	99%	10	Does Not Apply	10
Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision	97.1%	87.0%	275	97%	329	96%	9	0	9
Surgery Patients Whose Preventative Antibiotic(s) are Stopped Within 24 hours After Surgery	97.0%	79.0%	289	88%	318	94%	8	7	8

Overall Score

97%



Sample Medical Center Medicare Value-Based Purchasing (VBP) Score Analysis



Reporting Period											
Jul 2004 - Jun 2005	Oct 2004 - Sep 2005	Jan 2005 - Dec 2005	Apr 2005 - Mar 2006	Jul 2005 - Jun 2006	Oct 2005 - Sep 2006	Jan 2006 - Dec 2006	Apr 2006 - Mar 2007	Jul 2006 - Jun 2007	Oct 2006 - Sep 2007	Jan 2007 - Dec 2007	Apr 2007 - Mar 2008

Sample Medical Center

April 2004 - March 2005 Base Year	52%	53%	68%	73%	78%	83%	86%	90%	92%	97%	98%	98%
Most Recent April - March Base Year					70%	77%	82%	85%	84%	92%	96%	97%

Average Score - All United States Hospitals

April 2004 - March 2005 Base Year	57%	60%	64%	68%	72%	75%	77%	80%	82%	83%	85%	86%
Most Recent April - March Base Year					63%	67%	70%	73%	64%	67%	70%	73%

Average Score - California Hospitals

April 2004 - March 2005 Base Year	50%	47%	51%	55%	60%	65%	69%	73%	76%	79%	82%	84%
Most Recent April - March Base Year					63%	67%	71%	74%	63%	66%	70%	77%



Value-Based Purchasing Proposed Methodology (continued)

- The baseline and measurement period will be April 1 through March 31
- The hospital's grand total score is entered into the equation to determine a payment percentage
- If the maximum payment percentage is 100% of the hospital's original pool contribution, there will be excess money left in the pool
- A hospital's payment percentage will be determined at the start of each IPPS payment year
- The payment percentage will apply for the whole year
- The VBP carve-out and payment percentage will be applied to IPPS payments excluding IME, DSH, outliers and capital



Sample Medical Center

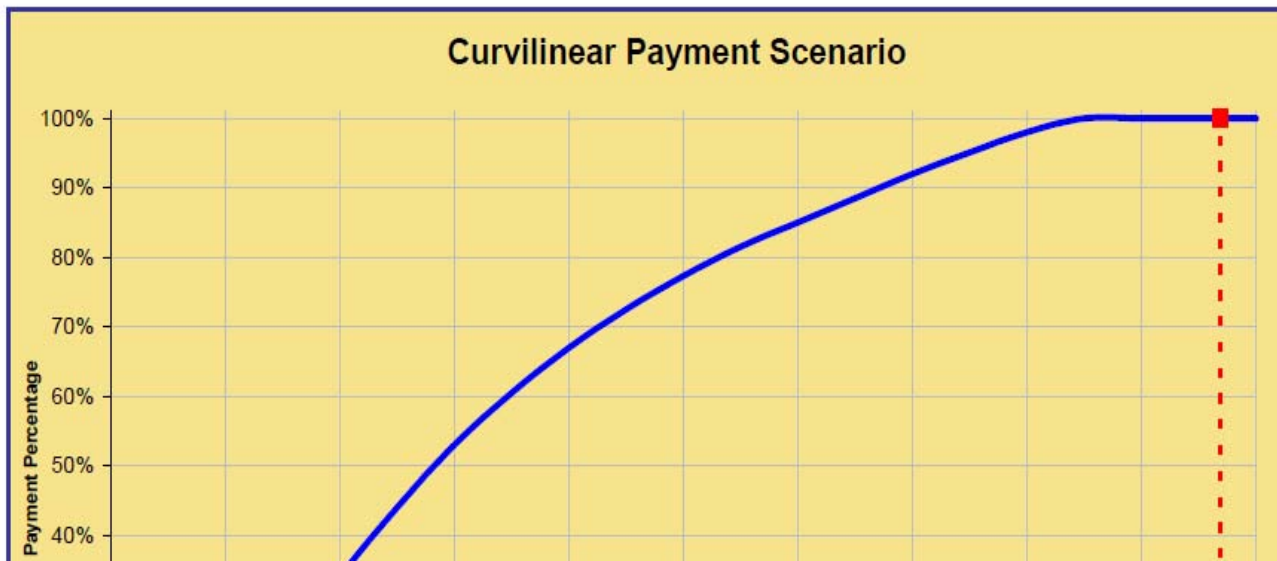
Payment Impact Estimate

Value-Based Purchasing

Scoring Period: April 2007 - March 2008

Assumes 5% Pool

	Curvilinear Payment Function	
	Sample Medical Center	California
Overall VBP Score	97%	77%
Payment Percentage	100%	93%
Dollars Contributed to VBP	\$2,087,000	\$460,032,000
Expected Payment from VBP	\$2,087,000	\$426,517,687
Net Loss from VBP	\$0	(\$33,514,313)





Value-Based Purchasing

- Hospitals' VBP scores and payment percentages will be established prospectively based upon performance
- The data reported between April 1, 2008 and March 31, 2009 will be the measurement year for FFY 2010 and the base year for FFY 2011
- Only top performers will be made whole
- Once we transition to VBP, hospitals still must participate in reporting of all data to qualify for incentive payments
 - Measures for VBP
 - Measures for Public Reporting
 - Measures being tested



Value-Based Purchasing Outstanding Questions

- How will mortality (outcome) measures be scored and incorporated? (*Report to Congress* makes no mention)
- Will indicators with small case counts be included?
- How will new indicators be phased in?
- How will the three domains' scores be weighted to arrive at the Total VBP score?
- What becomes of the excess pool funds?
 - The industry wants assurance that the entire pool will be distributed
 - MedPAC also recommends that there be no savings achieved through this program
 - How will distribution of excess dollars be handled?



Update on the Hospital Fee Proposal

Anne McLeod
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Hospital Fee Proposal

- Medi-Cal reimbursement rates lowest in country
 - \$2701 in California
 - \$4,662 national average
 - \$7,000 + in some states
 - \$3.7 Billion in uncompensated care costs for hospitals
 - \$2.5 Billion +/- in “upper payment limit” room



Hospital Fee Proposal

- Daughters of Charity Hospital System
 - Independent proposal
 - Outside consultants
 - Approached CHA Board



Hospital Fee Proposal

- CHA Board of Trustees
 - February 6, 2009
 - Endorsed the general “concept”
 - Leadership and management of CHA
 - Member participation
 - 2007 Board criteria



Hospital Fee Proposal

- 2007 CHA Board Criteria
 - Hospitals must be permanently protected with respect to payments and amount of tax.
 - Hospitals must be paid by Medi-Cal at the highest level allowed under federal law.
 - The state must be required to maintain its maintenance of effort.
 - All of the money generated from the hospital tax must be used solely to benefit hospitals.
 - Only the voters can change the program.



Hospital Fee Proposal

- Federal laws and regulations
 - Broad based and uniformly applied
 - Cannot just tax Medicaid
 - No direct or indirect guarantee to get as much back as paid in
 - Hold harmless provision
 - No direct correlation between taxes and payments
 - Statistical formula P1/P2 test



Hospital Fee Proposal

- 21 States have a Hospital Provider Tax
 - California is “different”
 - 440 hospitals
 - UPL room created by severe under funding
 - Broad range of business models
 - Uneven distribution of Medicaid population
 - » Geography
 - » Micro-economies
 - Results in significant redistribution



Hospital Fee Proposal

- CHA recommends two strategies
 - Short term solution
 - Take advantage of increased FMAP
 - Was 50/50, now 62/38
 - Through December 31, 2010
 - Longer term solution
 - Start January 1, 2011
 - June 2010 ballot initiative



Hospital Fee Proposal

- Risks!!!!
 - Legal
 - Legislative
 - Financial
 - Political



Hospital Fee Proposal

- Short term solution
 - Supplemental “add on” payments
 - Focus on easy, may not be perfect
 - Tight deadlines
 - Federal fiscal year considerations
 - October 1, 2008 – December 31, 2010



Hospital Fee Proposal

- Long term strategy
 - Very complex
 - CMAC – alternative solution
 - FMAP rate decreases back to 50/50
 - Timeline for this aggressive agenda is very tight.



Hospital Fee Proposal

- The current model
 - Available by end of next week.
 - Approach minimizes the harmful effects of redistribution to as many hospitals as possible.
 - CHA Board of Trustees has final authority to support or oppose any proposal.



Hospital Fee Proposal

- The current model
 - Tax method is per day (approximate!)
 - FFS \$300
 - Managed Care \$50
 - Rural/Small exempt from tax
 - Payments methods vary:
 - Inpatient per diem, based on pro-rata share of historical paid days (\$1000/\$750/%)
 - Outpatient is pro-rata share of UPL based on historical paid claims



Hospital Fee Proposal

- The current model
 - Six UPLs in California
 - Three Inpatient/Three Outpatient
 - » State owned public hospitals
 - » Non state owned public hospitals
 - » Private hospitals
 - Each pool is unique and each group of hospitals must not be paid at amounts greater than allowed by their UPL “room”.



Hospital Fee Proposal

- Next steps

- CHA must validate P1/P2 testing
- CHA in conjunction with DHCS must refine and finalize UPL estimates
- Lawyers must scrutinize
- Core workgroup to “kick the tires”
- Share with CHA Board and member hospitals
- Other



Thank you and questions

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