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Understanding Value-Based Purchasing

In October 2012, Medicare began rewarding hospitals that provide high-quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. Hospitals paid under the Inpatient Prospective Payment System (IPPS) are paid for inpatient acute care services based on quality of care — not the volume of services they provide.



Measures

The VBP program has 24 measures for FY 2016. Measures cannot be selected for VBP until they have been adopted for the hospital Inpatient Quality Reporting Program and posted on the Hospital Compare website for one year prior to the start of the VBP performance period.

Points

Each hospital may earn two scores on each measure — one for achievement and one for improvement. The final score awarded to a hospital for each measure or dimension is the higher of these two scores.

<p>Achievement Points: During the performance period, these are awarded by comparing an individual hospital's rates with the threshold, which is the median, or 50th percentile of all hospitals' performance during the baseline period, and the benchmark, which is the mean of the top decile, or approximately the 95th percentile during the baseline period.*</p> <ul style="list-style-type: none"> ■ Hospital rate at or above benchmark: 10 achievement points ■ Hospital rate below achievement threshold: 0 achievement points ■ Hospital rate equal to or greater than the achievement threshold and less than the benchmark: 1-9 achievement points 	<p>Improvement Points: Awarded by comparing a hospital's rates during the performance period to that same hospital's rates from the baseline period.</p> <ul style="list-style-type: none"> ■ Hospital rate at or above benchmark: 9 improvement points ■ Hospital rate at or below baseline period rate: 0 improvement points ■ Hospital rate between the baseline period rate and the benchmark: 0-9 improvement points
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Consistency Points: The consistency points relate only to the Patient Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in ALL eight dimensions of the HCAHPS. If they do, they receive the full 20 points. If they don't, the LOWEST dimension is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and awarded points proportionately. This formula is to be used for each dimension to determine the lowest dimension from the performance period:

$$\frac{\text{Your hospital performance period score} - \text{floor}}{\text{National achievement threshold} - \text{floor}}$$

*For the Medicare Spending per Beneficiary measure, the threshold and benchmark are based on all hospitals' rates in the performance period, rather than the baseline period.

This material was adapted with permission from a publication created by Stratis Health, the Medicare Quality Improvement Organization for the state of Minnesota.

SSI Points: There will be one SSI Measure score, which will be a weighted average based on predicted infections for both procedures:

$$\frac{(\text{SSI Colon measure score} \times \text{predicted infections}) + (\text{SSI Hysterectomy measure score} \times \text{predicted infections})}{\text{Predicted infections for both procedures}}$$

Domain Score

VBP measures roll up to a domain. FY 2014 has three domains: the Clinical Process of Care domain, the Patient Experience of Care domain, and the Outcome domain. Measure scores are added and divided by the total possible points x 100 to determine the Clinical Process of Care and Outcome domain scores. Dimension scores are added together to arrive at the HCAPHS base points. Base points plus the consistency score are added together to determine the Patient Experience of Care domain score. An additional domain (Efficiency) will be added in FY 2015.

Domain Weighting

The federal rule defines how much each domain will be weighted to calculate the Total Performance Score for each fiscal year. See pie charts in attached summaries for specific percentages for each domain.

Total Performance Score

A hospital's performance is assessed on the measures that comprise the domains. The domains are weighted and rolled up to the Total Performance Score. For instance, in FY 2014, the Total Performance Score is computed by multiplying the Clinical Process of Care domain score by 45 percent (domain weighting), the Patient Experience of Care domain score by 30 percent (domain weighting), and the Outcome domain score by 25 percent (domain weighting), then adding those totals. The Total Performance Score is then translated into an incentive payment that makes a portion of the base DRG payment contingent on performance.

Incentive Payment

In FY 2014, 1.25% of DRG payments to eligible hospitals will be withheld to provide the estimated \$1.1 billion necessary for the program incentives. Following is the schedule for future withholding:

FY 2013:	1.00 %	FY 2016:	1.75 %
FY 2014:	1.25 %	FY 2017:	2.00 %
FY 2015:	1.50 %	Succeeding years:	2.00 %

Based on performance, hospitals will earn an incentive payment. The law requires the Centers for Medicare & Medicaid Services (CMS) to redistribute the estimated \$1.1 billion across all participating hospitals, based on their performance scores. CMS uses a linear exchange function to distribute the available amount of value-based incentive payments to hospitals, based on hospitals' total performance scores on the hospital VBP measures. To convert the total performance score to a value-based incentive payment factor that is applied to each discharge, there are six steps for each fiscal year:

- Step 1:** Estimate the hospital's total annual base operating DRG amount.
- Step 2:** Calculate the estimated reduction amount across all eligible hospitals.
- Step 3:** Calculate the linear exchange function slope.
- Step 4:** For each hospital, calculate the value-based incentive payment percentage.
- Step 5:** Compute the net percentage change in the hospital's base operating DRG payment.
- Step 6:** Calculate the value-based incentive payment adjustment factor.

There is a review and correction period as well as an appeals process. This adjustment factor then is applied to the base DRG rate and affects payment for each discharge in the relevant fiscal year (October 1 – September 30).

Eligibility

Eligible hospitals are paid through the Inpatient Prospective Payment System, so critical access hospitals, children's hospitals, VA hospitals, long-term care facilities, psychiatric hospitals and rehabilitation hospitals are excluded. Eligible hospitals (PPS hospitals) become ineligible if the hospital:

- Is subject to payment reduction for the IQR program
- Has been cited for deficiencies that place the health or safety of patients in immediate jeopardy
- Does not meet the minimum number of cases, measures or domains (see table titled: Case Eligibility Criteria)

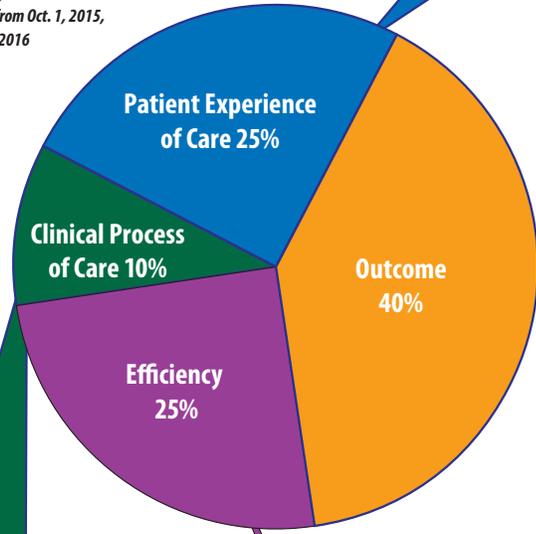
PPS hospitals that are ineligible do not have the initial monies withheld, nor do they receive an incentive payment.

CASE ELIGIBILITY CRITERIA				
FISCAL YEAR	DOMAINS			
	Clinical Process of Care	Patient Experience of Care	Outcome	Efficiency
FY2013 Requires scores in both domains to receive a Total Performance Score and be eligible for the VBP program	Requires four or more measures, each with at least 10 cases	Requires at least 100 HCAHPS surveys in the performance period		
FY2014 Requires scores in all three domains to receive a Total Performance Score and be eligible for the VBP program	Requires four or more measures, each with at least 10 cases	Requires at least 100 HCAHPS surveys in the performance period	30-day mortality for AMI, HF, and PN; each requires 10 cases minimum To receive a domain score, requires meeting the case criteria on two or more 30-day mortality measures	
FY2015 and FY2016 Requires scores in at least two of the four domains to receive a Total Performance Score For hospitals with at least two domain scores, the excluded domain weights will be proportionately distributed to the remaining domains	Requires four or more measures, each with at least 10 cases	Requires at least 100 HCAHPS surveys in the performance period	30-day mortality for AMI, HF, and PN; each requires 25 cases minimum PSI-90 requires three cases as a minimum for any one of the underlying indications CLABSI requires the hospital to have at least one predicted infection during the applicable period To receive a domain score, requires meeting the case criteria on two of the five measures	Medicare Spending per Beneficiary measure requires 25 cases

Final performance standards for the FY2016 hospital VBP program

Base operating DRG payment reduction amount: 1.75%

Payment adjustment effective for discharges from Oct. 1, 2015, to Sept. 30, 2016



Clinical Process of Care

BASELINE PERIOD		PERFORMANCE PERIOD	
Jan. 1–Dec. 31, 2012		Jan. 1–Dec. 31, 2014	
MEASURE ID	DESCRIPTION	ACHIEVEMENT THRESHOLD	BENCHMARK
AMI-7a	Fibrinolytic therapy received within 30 minutes of hospital arrival	0.91154	1.00000
PN-6	Initial antibiotic selection for CAP in immunocompetent patient	0.96552	1.00000
SCIP-Inf-2	Prophylactic antibiotic selection for surgical patients	0.99074	1.00000
SCIP-Inf-3	Prophylactic antibiotics discontinued within 24 hours after surgery end time	0.98086	1.00000
SCIP-Inf-9	Urinary catheter removed on postoperative day 1 or postoperative day 2	0.97059	1.00000
SCIP-Card-2	Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period	0.97727	1.00000
SCIP-VTE-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	0.98225	1.00000
NEW! IMM-2	Influenza immunization	0.90607	0.98875
REMOVED!			
AMI 8a PCI received within 90 minutes of hospital arrival			
HF 1 Discharge instructions			
PN 3b Blood culture before 1st antibiotic received in hospital			
SCIP 1 Abx within 1 hour before incision or within 2 hours if vancomycin/quinolone is used			
SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery			

Patient Experience of Care

BASELINE PERIOD		PERFORMANCE PERIOD	
Jan. 1–Dec. 31, 2012		Jan. 1–Dec. 31, 2014	
HCAHPS SURVEY DIMENSION	FLOOR	ACHIEVEMENT THRESHOLD	BENCHMARK
Communication with nurses	53.99%	77.67%	86.07%
Communication with doctors	57.01%	80.40%	88.56%
Responsiveness of hospital staff	38.21%	64.71%	79.76%
Pain management	48.96%	70.18%	78.16%
Communication about medicines	34.61%	62.33%	72.77%
Hospital cleanliness and quietness	43.08%	64.95%	79.10%
Discharge information	61.36%	84.70%	90.39%
Overall rating of hospital	34.95%	69.32%	83.97%

Outcome Measures

MORTALITY			
BASELINE PERIOD		PERFORMANCE PERIOD	
Oct. 1, 2010–June 30, 2011		Oct. 1, 2012–June 30, 2014	
MEASURE ID	DESCRIPTION	ACHIEVEMENT THRESHOLD	BENCHMARK
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	0.847472	0.862371
MORT-30-HF	Heart failure (HF) 30-day mortality rate	0.881510	0.900315
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.882651	0.904181

Complication/Patient Safety for Selected Indicators

BASELINE PERIOD		PERFORMANCE PERIOD	
Oct. 15, 2010–June 30, 2011		Oct. 15, 2012–June 30, 2014	
AHRQ (PSI-90)	DESCRIPTION	ACHIEVEMENT THRESHOLD	BENCHMARK
AHRQ (PSI-90)	Complication/patient safety for selected indicators (composite)	0.622879	0.451792

Healthcare Associated Infections

BASELINE PERIOD		PERFORMANCE PERIOD	
Jan. 1, 2012–Dec. 31, 2012*		Jan. 1, 2014–Dec. 31, 2014*	
Measure		Threshold (†)	Benchmark (†)
CLABSI	Central line-associated blood stream infection	0.465	0.000
NEW! CAUTI	Catheter-associated urinary tract infection	0.801	0.000
NEW! SSI	Colon ‡	0.668	0.000
	Abdominal hysterectomy ‡	0.752	0.000

*In proposed 2014 OPPS rule to be finalized Nov. 2013

†Standardized infection ratio

‡There will be one SSI measure score, which will be a weighted average based on predicted infections for both procedures.

Efficiency Measures

BASELINE PERIOD		PERFORMANCE PERIOD	
Jan. 1, 2012–Dec. 31, 2012		Jan. 1, 2014–Dec. 31, 2014	
MEASURE ID	DESCRIPTION	ACHIEVEMENT THRESHOLD	BENCHMARK
MSPB-1	Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile of Medicare spending per beneficiary ratios across all hospitals during the performance period