



National Advisory Committee On Rural Health and Human Services



Value-Based Purchasing Demonstrations for Critical Access and Small PPS Hospitals

White Paper September 2011

***Editorial Note:** In 2011, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of white papers with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.*

INTRODUCTION

Section 3001 of the Affordable Care Act established an inpatient hospital Value-Based Purchasing (VBP) program to start on or after October 1, 2012. The Affordable Care Act (ACA) expands previous quality reporting programs to include demonstrations for both Critical Access Hospitals (CAHs) and hospitals excluded from the inpatient VBP program based on low numbers of measures and cases. While VBP regulations for larger hospitals paid under the regular Medicare Inpatient Prospective Payment system (PPS) have been issued, HHS has yet to issue regulations or a solicitation for applications for CAH and low volume hospital VBP demonstrations.

The PPS VBP framework does provide a backdrop through which to begin considering how to construct these VBP demonstrations. The provisions for these PPS hospitals include a one-percent reduction in reimbursement to create a pool of funds to be used to reward hospitals that meet quality and cost improvement goals.

The PPS VBP is designed to provide incentives for these facilities to provide higher quality, more cost-effective care by reallocating their payments to fund the incentives. The Committee believes the ACA authorized the small hospital VBP demonstrations in recognition of the special circumstances faced by these facilities.

Recommendations

1. The Committee recommends that the Secretary group CAHs and other low-volume hospitals with their peers based on their inpatient average daily census and other relevant factors.
2. The Committee recommends that the Secretary use clinical inpatient measures that are specific to the characteristics of low-volume hospitals, such as heart failure, pneumonia, and HCAHPS, and that performance data is shared among peer group hospitals.
3. The Committee recommends that the Secretary use financial efficiency measures in addition to clinical measures when establishing incentive payments as this would provide incentives for hospitals to reduce the cost of administrative services and care practices, improving the value of services provided to Medicare patients.
4. The Committee recommends that the Secretary make available necessary technical assistance and support for the improvement of clinical and financial performance through the Medicare Quality Improvement Organizations and the Rural Hospital Flexibility program to any demonstration participants.
5. The Committee recommends that the Secretary develop the VBP program to include strong incentives to encourage participation of a diverse range of hospitals so that selection bias will not favor inclusion of top performing hospitals and skew the results of the demonstration.
6. The Committee recommends that the Secretary direct CMS to fund the incentive payments from actuarially projected savings resulting from increased efficiency to allow the continuation of cost based payments/hospital-specific rates while assuring the Medicare program's overall budget neutrality.

Consequently, the Committee believes an adoption of the same PPS VBP strategy will not work for CAHs and low-reporting PPS hospitals, many of which are paid under special payment provisions such as Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) methodologies. In order to assure the continued existence of these safety-net providers in rural communities, we will require a different approach for VBP. The ACA requires the Secretary to conduct a demonstration project to test an alternative approach. Like the main VBP program, this demonstration is required to be budget neutral with respect to the Medicare program as a whole. The pool of hospitals eligible to take part in this demonstration is overwhelmingly comprised of hospitals that are not paid on the traditional PPS methodology. Currently, there are 1,324 CAHs, 188 MDHs and 435 SCHs in the United States, the bulk of these facilities operating with 50 or fewer beds¹. All of these CAHs and small PPS hospitals will be potentially eligible for the demonstration but many operate on thin margins and face resource challenges that would make any financial penalties incurred under a demonstration program problematic.

DISCUSSION AND RECOMMENDATIONS

The Committee believes that the statutory requirement for a VBP Demonstration at these hospitals recognizes the need for the Centers for Medicare and Medicaid Services (CMS) to evaluate approaches for achieving VBP's goals in such a way that permits rewards for quality improvement and efficiency in the context of non-traditional reimbursement categories while maintaining budget neutrality. The comments below are directed toward this process.

COMMENTS REGARDING CLINICAL MEASUREMENTS AND PERFORMANCE

Historically, Medicare's hospital payment systems do not give hospitals strong incentives to manage care transitions, coordinate chronic diseases, or use best practices in a variety of clinical areas. This is changing, however, with the posting of quality data on Medicare Hospital-Compare and the advent of policies regarding reimbursement changes for preventable re-admissions and hospital-acquired conditions. The Committee believes that CMS should support clinical measures and data sharing that could improve patient care and outcomes in the VBP demonstration. However, the Committee recognizes that variability among small rural hospitals can result from a variety of factors unrelated to quality or efficiency. For example, staffing for most small hospitals is expected to provide minimum levels for all essential services as well as to cope with substantial variability in average daily census (ADC) due to such factors as flu outbreaks, severe trauma cases, or seasonal populations. In addition, there is great variability among CAHs themselves, as those with an ADC of around 25 tend to have a very different case mix and resource base than CAHs with an ADC less than 5. Clinical and cost measurements can be dramatically impacted by these differences.

The Committee recommends that hospitals within the demonstration be grouped with their peers and compared within these groups on their performance on selected measures in order to partially adjust for the above factors. Experience with physician practice information has shown that knowledge of peer group performance provides a powerful incentive to improve behavior². Similar results may be achieved by peer group comparisons among small hospitals. Performance data would be provided to demonstration participants so that hospitals below the mean would know their position relative to other providers. Lower performing hospitals could receive specific technical assistance with quality issues through the HHS-funded Rural Hospital Flexibility Program (Flex) and/or the Quality Improvement

¹ Sheps Center. Special data run from the OSCAR file. March 2011. Raw data. University of North Carolina, Chapel Hill, NC.

² Kiefe, C.I., *et al.* "Improving Quality Improvement Using Achievable Benchmarks for Physician Feedback." *Journal of the American Medical Association* 285.22 (2001): 2871-879.

Organizations (QIOs). The Flex Program along with other organizations also provides technical assistance to assist hospitals in identifying areas for improving care practices. For example, the Committee was impressed by the technical services currently offered by the Michigan Flex program in collaboration with the Michigan Hospital Association, which increased value and quality to patients and payers³. In addition, these peer group comparisons should highlight areas where collaboration or outsourcing may provide financial benefits as well as a way to highlight best practices among those in the demonstration. The demonstration program should set up an annual review process to assure that measurements, technical assistance, and improvements continue to be relevant and achieved.

The Committee understands that CMS is limited to the current available measure set when developing the VBP Demonstration parameters. Some measures may be less relevant to measuring clinical quality in rural areas than others. Because of this, the committee recommends that CMS focus solely on heart failure, pneumonia and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) as metrics for rural communities. Moreover, in order to increase statistical relevance in rural areas, data collection should be rolled up into longer periods of time. The Committee believes that the hospitals included in the demonstration should be an integral part of setting relevant measurements and that these measurements could differ among peer groups, depending on the specific needs of those hospitals.

COMMENTS REGARDING FINANCIAL MEASURES AND PERFORMANCE

The Committee supports the use of financial efficiency measures in addition to clinical quality measures in a VBP demonstration. This would provide incentives for hospitals to reduce the cost of administrative systems and care practices, which would improve the value of the services provided to CMS patients. Some states have utilized rural hospital collaborations to gather, analyze, and report information regarding various financial measures in addition to clinical quality metrics. The Committee believes such data sharing could improve the value of services to patients and payers by recognizing improved financial management, staff management, purchasing and information system practices. If necessary, the data could be blinded to prevent inappropriate use by competitors, regulators or third party payers. The Committee suggests that such collaborative efforts could be of substantial value and should be strongly encouraged in this demonstration project.

ACHIEVING SHARED SAVINGS THROUGH CLINICAL AND COST IMPROVEMENTS

Value-Based Purchasing programs cannot succeed unless there are financial rewards for those who achieve the program's goals. It is also clear from the method Congress has used to fund VBP for PPS hospitals that the funds to make such payments need to be financed by the improvements themselves so that the overall result is budget neutrality for the Medicare program.

The Committee cautions that many small hospitals have limited resources to devote to participating in a demonstration that requires significant time and administrative effort. Accordingly, the demonstration should avoid negatively affecting the hospitals that participate. Because of the importance of understanding the impact on this critical group of hospitals, strong incentives should be in place to encourage participation of a diverse group of hospitals. In particular, groups of hospitals with different ADC levels should be included. In order to avoid selection bias, the Committee recommends that the demonstration focus on an approach that can be undertaken with limited resources so that a diverse pool of participants can be selected.

³ Barnas, John. Executive Director, Michigan Center for Rural Health. Remarks at Meeting of the National Advisory Committee on Rural Health and Human Services. June 2011. Traverse City, MI.

The Committee notes that the context of cost reimbursement also holds the potential for the use of incentive payments in a budget neutral context. When payments are determined prospectively, the funds for incentive payments must be subtracted from the payments themselves (as is currently required). When payments are determined retrospectively, the amount available for incentive payments must be determined actuarially, by estimating the savings to the Medicare program that will accrue from the behavior being encouraged. We believe that this approach holds the promise of instituting effective VBP programs for cost-reimbursed providers.

The Committee believes there is a method by which a financial incentive could be created that would encourage participation while retaining the demonstration within the budget neutral parameters. This result could be achieved by actuarially forecasting the extent to which application of the strategies described above could be expected to reduce Medicare program costs during the period of the demonstration. CMS could then use funds amounting to the imputed savings to fund financial incentives to hospitals with superior quality and performance. This strategy could permit CMS to create incentives while still adhering to the statutory requirement that the demonstration be conducted in the context of overall Medicare program budget neutrality. If necessary, CMS could mandate outside technical assistance for those hospitals not producing appropriate progress toward improvements.

The Committee believes that such a demonstration could provide CMS with the general information it needs to pursue its VBP agenda. Such a demonstration must both adequately inform future policy through broad participation while avoiding the negative consequences of overly punitive penalties.

CONCLUSION

The Committee agrees that CAHs and other low volume hospitals will continue to need cost reimbursement if they are to continue to serve as safety net providers for rural communities. The Committee also believes that VBP can be used to enhance not only the quality of their care but also the effectiveness of their management. The Committee believes the recommendations in this White Paper will help achieve these goals and create a VBP system that incentivizes quality improvement and related efficiencies, maintains steady funding, and retains budget neutrality.