RUPRI Health Panel
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Rural Policy Research Institute Health Panel

CMS Value-Based Purchasing Program and Critical Access Hospitals

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The RUPRI Health Panel

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Preface

This report is a companion to the recently released "Rural Policy Research Institute Health Panel Response to CMS' *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program.*" In that report, the RUPRI Health Panel (the Panel) considered the Centers for Medicare and Medicaid Services' (CMS') proposed value-based purchasing (VBP) program and the implications for rural and/or low-volume prospective payment system (PPS) hospitals. Thus far, the developing CMS VBP discussion has not fully considered the unique characteristics of the critical access hospital (CAH) and the implications of VBP for cost-based reimbursement they receive. This second Panel report addresses VBP in the CAH context.

Introduction to the Report

Comprehensive quality improvement programs are an important advance in U.S. health care policy. Patients deserve to be safe in our nation's hospitals and should expect that their health care providers place quality care above all other priorities. Thus, quality improvement should be of critical strategic importance to hospitals. Yet, hospital-based quality improvement efforts may be costly and can negatively impact hospital financial performance. This financial reality is unacceptable in a health care system that strives to be safe, effective, patient-centered, timely, efficient, and equitable. Therefore, the Panel recommends that *CMS should continue to explore payment alternatives designed to improve the quality of hospital care—including VBP*—while considering effects on both short-term and long-term finances. Quality of care starts with access to care, and CAHs are essential to ensure availability of care in their communities.

Rural people represent nearly 20% of the U.S. population. Although rural/urban differences exist in patient demographics, hospital service mix, and patient volumes, hospital care is more similar across geographic boundaries and hospital size than dissimilar. In the interest of rural Medicare beneficiaries and the hospitals in which they receive care, the Panel strongly recommends that *CMS should include all CAHs in VBP, quality improvement technical assistance, and other quality improvement programs.* This perspective affirms that of the Institute of Medicine: "The committee emphasizes that rural providers should not be excluded from public reporting initiatives. Public disclosure and eventually pay-for-performance payment methods are potentially powerful incentives for encouraging improvements in quality. Rural providers, like urban, will benefit from these external levers for change as long as the performance measures are reliable and valid and the comparative reports are fair."[1]

Although the Panel supports many features of CMS' *Plan to Implement a Medicare Hospital Value-Based Purchasing Program,* the Panel also suggests several cautions regarding VBP program design and implementation, highlighted in this and the Panel's previous report. *While CMS should continue to develop a VBP program (as mandated by Congress in the Deficit Reduction Act of 2005), it should be sensitive to unique rural situations and carefully consider potential unintended program consequences.*

Critical Access Hospitals

Representing approximately 25% of all U.S. acute care hospitals, CAHs are a distinct class of hospitals by virtue of their separate Conditions of Participation, cost-based (plus 1%) Medicare reimbursement, and the Rural Hospital Flexibility (Flex) program policy goals. As defined by legislation and regulation,[2] CAHs are small rural hospitals limited to 25 inpatient beds and an average length of stay no greater than 96 hours (four days). CAHs represent the backbone of rural health care in their communities, providing local access to inpatient and outpatient care for rural people and a sense of safety and security for rural communities. CAHs often provide a comprehensive menu of inpatient services, including obstetrics, general surgery, and hospice. They also provide stabilization and transfer services to distant tertiary care centers, as well as a broad range of outpatient services, which often account for more than 50% of total hospital revenue.

CAH Value-Based Purchasing

Rural America is home to a disproportionately high percentage of Medicare beneficiaries. These beneficiaries and other rural citizens deserve the same health care quality, and quality improvement efforts/resources, as their urban counterparts. Rural provider exclusion (by intent or by oversight) from public reporting, quality improvement technical assistance, and VBP programs potentially places rural Medicare beneficiaries at risk for fewer improvement opportunities. Non-participation in CMS quality improvement programs could seriously disadvantage rural providers since Medicare beneficiaries may perceive non-participation as a marker of comparatively poor quality. An important goal of CMS' VBP program is to encourage hospital efficiency. While Congress has not required that CAHs be included along with PPS hospitals in a VBP program, they are not explicitly excluded either. CAH exclusion from the VBP program denies an opportunity to improve the efficiency of Medicare service delivery. Therefore, in the interest of rural Medicare beneficiaries and the hospitals in which they receive care, CMS should actively pursue VBP polices that specifically include CAHs.

Quality Improvement Capacity Building

Comprehensive clinical quality, consistent patient safety, and efficient resource use are the ultimate goals of any VBP program and are relevant to all hospitals, including CAHs. *Quality improvement capacity building, targeting small rural hospitals including CAHs, should be a fundamental component of any VBP program to ensure that all hospitals, regardless of size, type, or geographic location, can successfully participate in the program and have an equal opportunity to improve performance.* Therefore, *assisting CAHs with the development and acquisition of appropriately scaled quality-enhancing knowledge, skills, and health information technology (HIT) should be a priority.*

CMS lists "improve clinical quality"[3] as the first goal of its VBP initiatives. The Panel assumes that CMS desires improved clinical quality for services delivered to all Medicare beneficiaries, regardless of geographic location. The path to improved clinical quality is much more comprehensive than a reimbursement program. Resources such as appropriately trained and dedicated staff, accurate and timely data, clear and actionable performance reports, basic and ongoing educational opportunities, detailed and implementable quality improvement processes, and an organizational culture of continuous performance improvement are all critical components of a strategy to "improve clinical quality." Due to resource constraints, CAHs may have less access to these critical quality improvement resources and therefore may have less capacity for VBP success compared to larger, resource-rich, urban counterparts. For example, HIT is often cited as an important prerequisite for quality reporting (in turn, necessary for VBP). However, the HIT needed for hospital reporting may be cost prohibitive for some CAHs. The cost for any quality improvement resource (e.g., HIT or quality improvement professionals) will be higher per patient charge for low-volume hospitals due to fixed resource costs that can only be spread over a limited number of patients or services. To improve quality in a meaningful way, a VBP program should be offered in tandem with assistance to build necessary CAH quality improvement infrastructure.

The Panel believes that public reporting and financial incentives will not be enough to ensure that all rural providers have the opportunity and adequate resources to improve clinical quality. The VBP program must align with existing programs such as the Flex program, the Small Hospital Improvement program, and the Quality Improvement Organization (QIO) program to expand and target resources for CAH quality improvement capacity. For example, the current Flex program grant guidance requires state Flex program grant coordinators to encourage CAH participation in Hospital Compare and then to utilize Hospital Compare data to identify hospitals' needs for quality improvement technical assistance. Within a VBP program, the Panel recommends that *if any funds remain following VBP bonus distribution, those*

funds should be strategically distributed to established quality improvement programs.

Measure Options and Considerations

Performance Measure Selection

Patient care provided by CAHs is more similar to large rural and urban hospitals than dissimilar. CAHs are primary care hospitals, and VBP measures should not significantly vary for CAHs. However, while most performance measures will be germane to urban hospitals, rural PPS hospitals, and CAHs, differences in capacity lead to differences in the range of services offered. *Any hospital, regardless of size, type, or geographic location, should be evaluated only on services that it regularly provides.* For example, CAHs rarely care for inpatient acute myocardial infarctions (AMIs or heart attacks). Therefore, current CMS inpatient core measures for AMI are not appropriate for many CAHs. On the other hand, CAH emergency departments regularly care for AMI patients, and thus, emergency care of AMI would be an appropriate measure for CAH performance. Options for CAH VBP measures may include:

- Chest pain/AMI in the emergency department
- Heart failure
- Pneumonia
- Obstetric care
- Patient satisfaction (Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS])
- Patient transfers
- Outpatient satisfaction
- Hospital Leadership & Quality Assessment Tool participation
- AHRQ Hospital Survey on Patient Safety Culture participation
- Patient centeredness
- Responsiveness to community need
- HIT investment
- Care coordination

While mandating performance reporting for measures applicable to all CAHs (including measures related to patient safety and care in the emergency room), CMS may wish to allow CAHs to select from a menu of other services for performance measurement, reporting, and VBP incentives. Many CAH performance measures will be appropriate for all-hospital comparisons, while some measures may be appropriate only for inter-CAH comparisons. While for many CAHs, outpatient care is an emphasis, current VBP proposals recommend measurement of only inpatient care performance and thus would preclude CAHs from demonstrating value in their most

frequently provided services. *A CAH VBP program should include measurement of services commonly provided by CAHs, including outpatient care.*

Statistical Considerations

CAHs provide care to fewer patients than larger hospitals. Low CAH volumes can lead to reported performance variation due to chance, not due to hospital performance. Statistical reliability of VBP measures is a key issue for CAHs. Thus, *CMS should mandate appropriate measure selection and sophisticated statistical analysis to ensure that low volumes do not significantly reduce measure reliability.* This concern is greatest with low prevalence clinical outcomes such as mortality. Nonetheless, the Panel believes CMS should include CAHs in VBP in spite of more challenging statistical analysis. To promote inter-hospital collaboration and health care regionalization, statistical shrinkage methods could be used, such as adjusting observed or raw scores by blending them with averages or estimates borrowed from other hospitals. Using these methods would require CMS to reconsider its comment that "this method conflicts with the policy goals of VBP to provide reliable public reporting and financial incentives based on a hospital's individual performance."[3] Interestingly, in its VBP report to Congress, CMS does not explicitly list financial incentives based on a hospital's individual performance as a VBP policy goal. Yet, in the spirit of transparency, the Panel recognizes that individual hospital performance reporting is important. However, reporting invalid or unreliable data, let alone basing VBP incentives on invalid or unreliable data, is counterproductive. CMS should consider new methods such as regional roll-ups and multi-year data aggregations to achieve statistical reliability during performance analysis.

Public Reporting

The VBP development process begins first with data collection, followed by public reporting, and lastly payment linked to performance. Since incentive payment is predicated on data collection and public reporting, performance data must be accurate and public reporting processes must reliably reflect individual hospital performance. Obstacles to reporting may be created by low CAH volumes, insufficient CAH data collection and reporting capacity, or both. Although the Panel strongly supports CAH inclusion in the VBP program, *CMS should immediately begin to identify obstacles to CAH performance reporting and then provide adequate resources to ensure universal and accurate CAH performance reporting.* As a strategy to deliver those resources, the Panel supports CMS' comment that "CMS could modify and expand the technical assistance provided to hospitals in improving quality of care and quality measurement through its 53 QIOs."[3] CMS continues by stating, "An emphasis of the QIOs' role could be to provide technical assistance to small and rural hospitals that have more limited infrastructure to support quality improvement

interventions, to hospitals with disparities in care among subgroups of patients, and to hospitals with poor performance scores."[3] This focus on technical assistance addresses some of the Panel's concerns about CAHs' lack of resources to implement VBP. However, CMS' 9th Scope of Work for QIOs markedly decreases the resources available for rural assistance. *VBP success is contingent on adequate technical assistance, and CMS should reconsider its decision to defund a rural priority for QIO work and should collaborate with other offices within the Department of Health and Human Services to identify and expand technical assistance resources such as the Flex grant program and the Small Rural Hospital Improvement grant program.*

VBP Financing

The VBP policy debate often considers the use and effectiveness of rewards and penalties, and how those rewards or penalties should be applied to hospitals. When designing a reward program, the method by which CMS reimburses a hospital is important. In the cost-based reimbursement context (CAHs), one may argue that there is little or no need to reward hospitals for positive performance. Quality improvement costs should be included in cost-based reimbursement accounting. However, Medicare reimburses at cost plus 1% (101%) only for the percentage of a CAH's revenue attributable to Medicare. For example, if Medicare represents 50% of a CAH's revenue, then only 50% of quality improvement costs are reimbursable at cost by Medicare. Thus, Medicare cost-based reimbursement will never pay for all CAH quality improvement investments. Despite cost-based reimbursement, CAH margins remain low. Financial incentives are still needed to promote quality.

Congress created the CAH designation in the Flex program to reduce the financial risk incurred by small rural hospitals unable to generate efficiencies (and profits) made possible by high service volumes. A payment system designed to reimburse each encounter based on average costs (PPS) creates the possibility of severe financial shortfalls that threaten the financial survivability of very small but essential hospitals. Similar to what can happen in a PPS environment, in a budget-neutral environment VBP produces "winners and losers." Therefore, without an adequate phase-in period and resources to develop appropriate data reporting and quality improvement processes, VBP could jeopardize the financial survival of some CAHs by creating the same scenario the Flex program seeks to ameliorate. Therefore, *CMS should implement a hold harmless VBP phase-in period (there is precedence in other payment systems such as outpatient PPS and the ambulance fee schedule) and provide CAHs the resources (for example, through targeted Flex program funding) to effectively report quality performance and improve clinical quality.*

The issue of budget neutrality is fundamental to health care financing discussions. Although budget neutrality mandates permeate Medicare policy discussions, cost-

based reimbursement is not budget-neutral. However, the Medicare budgetary impact of CAH cost-based reimbursement is relatively minor. Expenditures for CAH services represent approximately 2% of all Medicare spending for short-term acute hospital services. An additional incentive payment of 1%, for example, would represent only .02% of total Medicare spending on short-term acute hospital services. Therefore, changes could be made to the CAH reimbursement system that could potentially improve individual CAH quality, with only minor impact on Medicare spending. However, the Panel believes that *any CAH VBP payment plan requires careful financial scoring and assessment of potential unintended consequences prior to implementation.*

The design of a CAH VBP payment and incentive strategy requires further dialogue. Possible approaches include those that (1) maintain the current base payment rate and provide additional funding for bonuses, (2) lower the base payment rate and incent hospitals to earn quality-related bonuses that bring them up to the current base payment rate, (3) lower the base payment rate and incent hospitals to earn quality-related bonuses to an amount lesser or greater than the base payment rate, or (4) are a combination of payment approaches. The Panel presents three reimbursement examples as illustrations of possible payment approaches, each evaluated by three consequences: cost to the Medicare program (Medicare Cost), financial risk incurred by the CAH (CAH Risk), and likelihood of clinical quality improvement (Quality Impact). The examples presented are not exhaustive; additional options may be considered.

VBP Financing Examples	Medicare Cost	CAH Risk	Quality Impact
<u>Example 1</u> • Year 1: All CAHs receive 101% of cost; additional bonus of 1% if quality criteria achieved	↑	**0**	↑
• Years 2/3: All CAHs receive 100% of cost; additional bonus of 2% if quality criteria achieved	↑	↑	↑↑
• Years 4/5: All CAHs receive 95% of cost; additional bonus of 6% if quality criteria achieved	**0**	↑↑↑	↑↑↑
<u>Example 2</u> • All CAHs receive 101% of cost; additional 2% bonus if quality criteria achieved	↑↑	**0**	↑↑
<u>Example 3</u> • All CAHs receive 100% of cost; additional 2% bonus if quality criteria achieved	↑	↑	↑

The Panel anticipates that VBP funding as a percent of total CAH payment will be increased over time (e.g., funding for bonuses increases to 2%, 3%, 4%, etc.) as experience with the VBP program accrues, inevitable process and system problems are rectified, and unintended consequences resolved. Concurrently, CMS will likely place an increasing proportion of CAH reimbursement at risk. *As CAH reimbursement risk increases, CMS should ensure that essential hospital services remain accessible to rural beneficiaries by providing quality improvement resources to CAHs, with concomitant expectations for measurable improvement.*

Conclusion

The Panel strongly recommends that CMS include CAHs in VBP, quality improvement technical assistance, and other quality improvement initiatives. While cost-based reimbursement and low volumes make CAH inclusion in VBP challenging, the challenges should not dissuade policy makers from endorsing and supporting a path to CAH inclusion in VBP. Demonstration projects are an appropriate entry strategy and should be implemented as quickly as possible. Doing so avoids introducing CAHs into a program with pre-established parameters that may not be sensitive to CAH characteristics. *Support for quality improvement capacity building should begin now in preparation for a VBP program that incentivizes and recognizes the value and quality CAHs bring to rural Medicare beneficiaries.*

References

[1]Committee on the Future of Rural Health Care. 2005. *Quality Through Collaboration: The Future of Rural Health.* Washington, DC: The National Academies Press.

[2]Balanced Budget Act of 1997, Public Law 105-32, Subtitle C, Section 4201; 42 U.S.C. 1395i-4.

[3]Centers for Medicare & Medicaid Services. 2007. Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program. Washington, DC: U.S. Department of Health and Human Services.

Recommendation Summary

- CMS should continue to explore payment alternatives designed to improve the quality of hospital care—including VBP.
- CMS should include all CAHs in VBP, quality improvement technical assistance, and other quality improvement programs.
- While CMS should continue to develop a VBP program (as mandated by Congress in the Deficit Reduction Act of 2005), it should be sensitive to unique rural situations and carefully consider potential unintended program consequences.
- Quality improvement capacity building, targeting small rural hospitals including CAHs, should be a fundamental component of any VBP program to ensure that all hospitals, regardless of size, type, or geographic location, can successfully participate in the program and have an equal opportunity to improve performance.
- Assisting CAHs with the development and acquisition of appropriately scaled quality-enhancing knowledge, skills, and HIT should be a priority.
- If any funds remain following VBP bonus distribution, those funds should be strategically distributed to established quality improvement programs.
- Any hospital, regardless of size, type, or geographic location, should be evaluated only on services that it regularly provides.
- A CAH VBP program should include measurement of services commonly provided by CAHs, including outpatient care.
- CMS should mandate appropriate measure selection and sophisticated statistical analysis to ensure that low volumes do not significantly reduce measure reliability.
- CMS should immediately begin to identify obstacles to CAH performance reporting and then provide adequate resources to ensure universal and accurate CAH performance reporting.
- VBP success is contingent on adequate technical assistance, and CMS should reverse its decision to defund a rural priority for QIO work and should collaborate with other offices within the Department of Health and Human Services to identify and expand technical assistance resources such as the Flex grant program and the Small Rural Hospital Improvement grant program.

- CMS should implement a hold harmless VBP phase-in period (there is precedence in other payment systems such as outpatient PPS and the ambulance fee schedule) and provide CAHs the resources (for example, through targeted Flex program funding) to effectively report quality performance and improve clinical quality.

- Any CAH VBP payment plan requires careful financial scoring and assessment of potential unintended consequences prior to implementation.

- As CAH reimbursement risk increases, CMS should ensure that essential hospital services remain accessible to rural beneficiaries by providing quality improvement resources to CAHs, with concomitant expectations for measurable improvement.

- Support for quality improvement capacity building should begin now in preparation for a VBP program that incentivizes and recognizes the value and quality CAHs bring to rural Medicare beneficiaries.

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