Frequently Asked Questions
Hospital Value-Based Purchasing Program
Last Updated March 9, 2012

This document is intended to provide hospitals and other interested parties with technical details about the Hospital Value-Based Purchasing Program. It addresses:

- The Program's Background;
- Hospital Eligibility;
- Incentive Payments;
- Performance Periods;
- Performance Assessment;
- Performance Measures;
- Calculating Performance Scores;
- Translating Scores into Payments;
- Public Reporting;
- Appeals;
- Information CMS Shares with Hospitals;
- Dry Run Reporting; and
- Special Information for Critical Access Hospitals.

Hospitals and hospital stakeholders with questions about the Program that are not addressed here can submit a question to HospitalVBP@cms.hhs.gov.

Questions new since our last update of the Frequently Asked Questions are flagged as 

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Beneficiaries and consumers are encouraged to learn more about the Hospital Value-based Purchasing Program on Medicare's *Hospital Compare* website, online at http://www.hospitalcompare.hhs.gov.

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Frequently Asked Questions
Hospital Value-Based Purchasing Program
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Program Background

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1. What is Hospital Value-Based Purchasing?

The Hospital Value-Based Purchasing (VBP) Program is a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare.

2. What is Medicare doing to improve the quality of care in hospitals?

Through the Hospital Value-Based Purchasing Program, CMS is changing the way it pays hospitals, rewarding hospitals for the quality of care they provide to Medicare patients, not just the quantity of procedures they perform. Hospitals are rewarded based on how closely they follow best clinical practices and how well hospitals enhance patients' experiences of care. When hospitals follow proven best practices, patients receive higher quality care and see better outcomes. Hospital VBP is just one initiative CMS is undertaking to improve the quality of care Medicare beneficiaries receive.

3. How was the Hospital Value-Based Purchasing Program established?

The Hospital VBP Program was established by the Affordable Care Act of 2010 (ACA), which added Section 1886(o) to the Social Security Act. The law requires the Secretary of the Department of Health and Human Services (HHS) to establish a value-based purchasing program for inpatient hospitals. To improve quality, the ACA builds on earlier legislation—the 2003 Medicare Prescription Drug, Improvement, and Modernization Act and the 2005 Deficit Reduction Act. These earlier laws established a way for Medicare to pay hospitals for reporting on quality measures, a necessary step in the process of paying for quality rather than quantity.

4. When will Medicare start paying hospitals based on the quality of care they provide?

Hospitals participating in the Hospital Value-Based Purchasing Program will begin to receive incentive payments for providing high quality care or improving care after October 1, 2012, the start of Fiscal Year 2013. The incentive payments will be based on a hospital's performance during the period from July 1, 2011, to March 31, 2012.

5. When will the next release of proposed Hospital VBP changes be released? Will there be another Hospital VBP-specific rule, or will updates take place in the IPPS or OPPS rules?

At this time, CMS intends to conduct rulemaking related to Hospital VBP through the annual IPPS rule (which is generally proposed in April and finalized in July) and, if necessary, through the OPPS rule (generally proposed in July and finalized in October). If another standalone regulation becomes necessary, we will make every effort to ensure that hospitals are aware of it.

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Hospital Eligibility

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6. What hospitals are participating in the Hospital Value-Based Purchasing Program?

More than 3,000 hospitals across the country are eligible to participate in Hospital VBP. The program applies to subsection (d) hospitals located in the 50 states and the District of Columbia and acute-care hospitals in Maryland. Hospital VBP is based on data collected through the Hospital Inpatient Quality Reporting (IQR) Program. More details about the Hospital IQR program are online at https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp.

The following hospitals are excluded from Hospital VBP:

- Hospitals and hospital units excluded from the Inpatient Prospective Payment System, such as psychiatric, rehabilitation, long-term care, children's, and cancer hospitals;
- Hospitals that do not participate in Hospital IQR during the Hospital VBP performance period;
- Hospitals cited by the Secretary of HHS for deficiencies during the performance period that pose an immediate jeopardy to patients' health or safety; and
- Hospitals that do not meet the minimum number of cases, measures, or surveys required by Hospital VBP.

The Secretary of HHS can exempt some hospitals paid under Section 1814(b)(3) of the Social Security Act from participating in the Hospital VBP Program. These hospitals must be in a state that submits an annual report to the Secretary describing how a similar state program for a participating hospital or hospitals achieves or surpasses Hospital VBP in its measured results for patient health outcomes and cost savings. Hospitals in the state of Maryland have received such an exemption and are thus exempt from the FY 2013 Hospital VBP Program.

7. What happens if a hospital decides not to participate in the Hospital Value-Based Purchasing Program?

CMS hopes that all applicable hospitals will want to participate in this program designed to improve the quality of care offered to patients and to receive value-based incentive payments.

8. One eligibility requirement of the Hospital Value-Based Purchasing Program is that hospitals must have a minimum number of cases. What is the minimum number of cases?

To be eligible, hospitals must report on at least four Hospital VBP measures during the performance period, with a minimum of 10 cases per measure. This number was established through an analysis conducted by two independent entities, Brandeis University and RAND Corporation**.** In this analysis, CMS sought to balance the need for statistically reliable scores with the policy goal of including as many hospitals as possible in the Hospital VBP Program. Through a separate analysis, RAND Corporation determined that hospitals must report the results of at least 100 HCAHPS surveys to meet eligibility requirements for the Patient Experience of Care domain.

**9. 
My hospital has too few cases to count in at least 2 of the measures. This is true of the baseline and performance periods. Is my hospital exempt from Hospital VBP?**

In the Clinical Process of Care domain, hospitals without at least 10 cases on at least 4 measures in the performance period will be excluded from the Hospital VBP Program for that year. Since the FY 2013 Program uses 12 finalized Clinical Process measures, hospitals could have insufficient data on up to 8 measures and still participate in the program, provided they have sufficient HCAHPS surveys for the Patient Experience of Care domain requirement.

**10. 
If we do not have enough cases for inclusion in clinical measures, are we dropped from entire VBP Program or will our percent still apply via HCAHPS?**

In order to receive a Total Performance Score for the FY 2013 Program, hospitals must have sufficient data in both the Clinical Process of Care and Patient Experience of Care domains. If your facility does not have sufficient Clinical Process of Care data but has sufficient HCAHPS data, your hospital will be excluded from the FY 2013 Program.

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11. What is the source of funding for incentive payments that will be paid to hospitals through the Hospital Value-Based Purchasing Program?

Hospital VBP incentive payments to hospitals will come from the regular fees Medicare pays hospitals through its Diagnosis-Related Group (DRG) system. Hospitals participating in Hospital VBP will have their base operating DRG payments for each patient discharge across all hospitals reduced by a small percentage each year. That money will be used to fund incentive payments for hospitals participating in Hospital VBP.

The base operating DRG percent reduction is 1.0 percent for Fiscal Year (FY) 2013, 1.25 percent for FY 2014, 1.5 percent for FY 2015, 1.75 percent for FY 2016, and 2 percent for FY 2017 and subsequent years. Section 1886(o)(7) of the Social Security Act describes the funding mechanism.

12. When and how will hospitals be notified about their incentive payments through the Hospital Value-Based Purchasing Program?

At least 60 days before October 1, 2012, CMS will notify each hospital participating in Hospital VBP of its estimated value-based incentive payment for each patient discharge in Fiscal Year (FY) 2013 through that hospital's QualityNet account.

On November 1, 2012, hospitals will be notified of their exact value-based incentive payments for each FY 2013 discharge. The exact value-based incentive payment will depend on each hospital's total performance score.

More information about the QualityNet account system is online at http://www.qualitynet.org.

13. What level of incentive payment can hospitals expect to receive through the Hospital Value-Based Purchasing Program?

Taking into account the reduction in base Diagnosis-Related Group operating payments to hospitals (1 percent for Fiscal Year 2013), CMS estimates that **roughly half** of participating hospitals will receive a net increase in payments as a result of this rule, while the rest will receive a net decrease in payments. CMS estimates that no participating hospital will receive more than a net 1-percent decrease in payments in FY 2013. Possible increases depend on the distribution of hospitals' performance scores.

14. Is there a tool or program my hospital can use to identify the dollars at risk by Hospital VBP measurement?

Hospitals will be at risk for 1.0% of base operating Diagnosis-related Group (DRG) amounts for the FY 2013 Program. As required by the statute, that percentage will rise to 2.0% by FY 2017. CMS does not offer or recommend a specific tool; however, there may be several tools and resources available that will give hospitals an estimate of their performance for FY 2013.

15. How will the results of Hospital VBP affect payments to each hospital? Is there an adjustment to the base rate?

The Hospital VBP statute requires CMS to adjust each hospital's "base operating DRG amount" and provide value-based incentive payments. In FY 2013, hospitals will be at risk for 1% of base operating DRG amounts and will receive an incentive payment based on their Total Performance Scores. We will provide specific payment information in each hospital's scoring report, which we intend to provide via QualityNet by November 1, 2012.

16. What is the plan for the 1% contribution (i.e., when and how)?

We intend to provide additional detail on operational and payment plans in the FY 2013 IPPS/LTCH rule. As described in prior rulemaking, however, we note that we anticipate making the final changes to our claims system to accommodate the Hospital VBP program in January 2013.

17. What is the best method to calculate your Hospital VBP incentive?

CMS provided information about Total Performance Score calculation methodology as well as the Simulated Reports during the February 28, 2012 National Provider Call. Slides from that call are online at http://www.cms.gov/hospital-value-based-purchasing.

18. How can facilities best prepare so that they do not experience negative financial impacts when payment adjustments begin under the FY 13 Hospital VBP?

Eligible hospitals should review their hospital's Simulated Report for at least two critical areas:

1. Strengths and weakness in the scoring domains to narrow down areas for improvement; also, the number of cases you might need to receive a score in another measure for the Clinical Process of Care Domain.
2. Impact of the Hospital VBP Program on Medicare DRG reimbursement for FY 2013.

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Performance Periods

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19. What is a performance period for the Hospital Value-Based Payment Program?

A Hospital VBP performance period is a designated time span used to capture data that indicates how well a hospital is performing based on an established set of quality measures. Data collected during the performance period is compared to data collected for each participating hospital during a baseline period. CMS uses this comparison to determine improvements in quality.

20. When does the first Hospital Value-Based Payment Program performance period start?

The first Hospital VBP performance period began July 1, 2011, and will end March 31, 2012. In future years, the performance period will be a full year. The three-quarter performance period in the first year of Hospital VBP was necessitated by implementation dates contained in the Affordable Care Act.

21. How long is the first year's (FY 2013) performance period?

For FY 2013, the performance period spans three quarters from July 1, 2011 - March 31, 2012.

22. How accurately will hospital quality of care and improvement in care be measured during the shortened three-quarter performance period for the inaugural year of the Hospital Value-Based Purchasing Program compared to a full year of measurement?

Based on analysis conducted by CMS, the three-quarter performance period demonstrated a high level of correlation with a full-year performance period and is appropriate to serve as the basis for the Fiscal Year 2013 Hospital VBP Program incentive payments.

**23. 

Please clarify the timeframe of the Patient Experience Measures for FY 13 of the Hospital VBP, i.e., third quarter 2011 through first quarter 2012. Are those timeframes associated with the surveys conducted with patients during that period, the results of which are not submitted fully to CMS until July 2012? Or rather, does that timeframe map back to the submission of HCAHPS survey results during that timeframe (i.e., for surveys conducted April through December 2011)?**

The performance period for the Patient Experience of Care domain for the FY 2013 Hospital VBP Program is July 1, 2011 to March 31, 2012. HCAHPS surveys issued for discharges during that performance period will be used to calculate HCAHPS scores for purposes of the FY 2013 Total Performance Score.

24. Please explain why Hospital Compare publishes four quarters of data while the baseline and measurement periods for Hospital VBP represent just three quarters of data.

Although CMS would have preferred to use a full year as the performance period for Fiscal Year 2013, CMS concluded that this would not provide sufficient time to calculate the Total Performance Scores and value-based incentive payments, notify hospitals regarding their payment adjustments, and implement the payment adjustments. Therefore, for FY 2013, CMS is finalizing the performance period described above as a three-quarter performance period, from July 1, 2011 to March 31, 2012.

25. When will be benchmarks be set for FY 14? What is the FY 14 baseline period?

Benchmarks and achievement thresholds for the FY 2014 Program were posted in the CY 2012 OPPS / ASC Final Rule. The full regulation may be found here: http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf.

The baseline period for the Clinical Process and Patient Experience domains for FY 2014 is April 1, 2010 to December 31, 2010. The baseline period for the Outcomes domain for FY 2014 is July 1, 2009 to June 30, 2010.

26. Where can we find the FY 13 benchmark period data for our specific hospital and for the all-hospital set?

Benchmarks are set based on all hospitals' data from the baseline period and represent a high level of performance that CMS intends to reward. You may find all of the FY 2013 Program's benchmarks in the Hospital Inpatient VBP Final Rule, available at: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf.

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Performance Assessment

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27. What is the fundamental methodology behind the Hospital Value-Based Purchasing Program?

CMS will assess each hospital's total performance by comparing its achievement and improvement scores for each applicable Hospital VBP measure and awarding the higher score for each measure. CMS will then aggregate each hospital's scores into the appropriate domain.

The Fiscal Year (FY) 2013 Hospital VBP Program consists of two domains: **1) Clinical Process of Care** and **2) Patient Experience of Care**. The Clinical Process of Care score is simply the sum of measure scores in that domain. The Patient Experience of Care score is the

sum of a hospital's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) base score and that hospital's HCAHPS Consistency score. (Question 39 provides more detail about how the two domains will make up the total performance score.)

CMS will then multiply each domain score by domain-specific weights. For FY 2013, these weighted values are **70 percent** for Clinical Process of Care and **30 percent** for Patient Experience of Care. After each domain score is multiplied by its percentage value, CMS will add the weighted domain scores to reach a hospital's Total Performance Score.

Each hospital's Total Performance Score will be converted into a value-based incentive payment adjustment percentage using a mathematical formula. In FY 2013, CMS will use a specific formula that translates hospitals' scores into incentive payment adjustment percentages by ranking all hospitals based on their scores. CMS will ensure that the total incentive payments do not exceed the total amount estimated to be withheld in FY 2013 under Social Security Act Section 1886(o)(7)(B). (Questions 50 and 51 provide more detail about how performance scores are translated into payment amounts.)

28. How will hospitals be evaluated under the Hospital Value-Based Purchasing Program?

To measure improvement, CMS will assess how much each hospital's **performance** during the performance period changes from its own **baseline period performance**. CMS will award points to hospitals based on their level of improvement between that baseline score and the benchmark score. CMS will only award points for improvement if a hospital's performance during the performance period is greater than its performance during the baseline period.

To measure achievement, CMS will assess how much each hospital's performance during the performance period differs from the performance of **all other hospitals** during the baseline period. CMS will only award achievement points if a hospital's performance during the performance period exceeds the 50th percentile of all hospitals' performance during the baseline period. The 50th percentile is defined by CMS as the "achievement threshold."

29. What happens to a hospital without any baseline data or with insufficient baseline data?

If a hospital does not have performance data in the baseline period, that hospital will only be evaluated on achievement. For example, if a hospital does not have a minimum of 10 cases on a given measure in the baseline period, then there is insufficient data with which to calculate an improvement score. In this case, the hospital would not be scored on improvement for that measure. Hospitals not scored on improvement for a given measure, however, will still have the opportunity to score up to 10 *achievement* points on that measure.

30. Should hospitals be compared against similar hospitals rather than against all hospitals?

CMS believes that achievement thresholds and benchmarks based on national data provide balanced, appropriate standards of high quality care for hospitals to work towards under the Hospital VBP Program. CMS also notes that consumers will be able to compare similar hospitals' performance on quality metrics as they currently do on the Hospital Compare website.

31.  Are our baseline and performance scores based solely on Medicare patient data?

In general, chart-abstracted and survey measures capture the hospital's entire patient population. Claims-based measures, such as the mortality measures that have been finalized for the FY 2014 Program, are based solely on Medicare data.

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Performance Measures

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32. What quality measures will be used to evaluate hospitals for the Hospital Value-Based Purchasing Program?

CMS has adopted 13 of 45 quality measures tracked in the Hospital Inpatient Quality Reporting Program for the Fiscal Year (FY) 2013 Hospital VBP Program.
The FY 2013 measures are provided in the table on the next page.

Clinical Process of Care Measures	
Measure ID	**Measure Description**
Acute Myocardial Infarction (AMI)	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival
Heart Failure (HF)	
HF-1	Discharge Instructions
Pneumonia (PN)	
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient
Healthcare-associated Infections (SCIP = Surgical Care Improvement Project)	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6:00 a.m. Postoperative Serum Glucose
Surgeries	
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Survey Measures	
Measure ID	**Measure Description**
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey

For FY 2014, CMS also adopted the following measures into the Outcome domain:

- Three mortality outcomes measures, covering acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN)

33. What measures from the Hospital Inpatient Quality Reporting (Hospital IQR) Program have not been included in the Hospital VBP Program?

For the Fiscal Year 2013 Hospital Value-Based Purchasing Program, CMS excluded the measures PN-2 and PN-7, since data collection will no longer be required on these measures after December 30, 2011.

The following 10 measures have also been excluded because CMS concluded that these measures are "topped-out." This means that nearly all hospitals have achieved a similar high level of performance on these measures, and using these measures would result in a performance standard that is not significantly different from the highest attainable score. In CMS' view, using these topped out measures could lead to unintended consequences:

- AMI-1 – Aspirin at Arrival
- AMI-3 – Angiotensin-Converting Enzyme Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) at Discharge
- AMI-4 – Smoking Cessation
- AMI-5 – Beta Blocker at Discharge
- HF-4 – Smoking Cessation
- PN-4 – Smoking Cessation
- SCIP-Inf-6 – Surgery Patients with Appropriate Hair Removal
- AMI-2 – Aspirin Prescribed at Discharge
- HF-2 – Evaluation of Left Ventricular Systolic (LVS) Function
- HF-3 – ACEI or ARB for Left Ventricular Systolic Dysfunction (LVSD)

34. Do all of these measures apply to all hospitals?

If a hospital does not provide services appropriate to a specific measure, then that measure does not apply to that hospital.

35. Is it appropriate to use claims-based measures for payment purposes?

Yes. CMS will use the final adjudicated claim submitted by hospitals for the Hospital VBP Program. Adjudicated claims are currently used by CMS for other reasons (for example, to investigate fraud and abuse) and have been found to provide CMS with reliable and valid data.

**36. 

How is the data collected for measures? What are the denominator populations, and how will the time periods work going forward?**

For a list of measures and how data is collected, hospitals may visit the "For Professionals" section of the Hospital Compare website at: http://www.hospitalcompare.hhs.gov/staticpages/for-professionals/poc/data-collection.aspx/. In addition, detailed information regarding measure specifications and calculation for rates is available at http://www.qualitynet.org/.

CMS intends to propose all future baseline periods and to set performance period end dates for any measure selected for future Hospital VBP Program years in future rulemaking.

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Calculating Performance Scores

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37. Against what will a hospital's performance be compared?

CMS will assess a hospital's performance on each Hospital VBP measure using an achievement threshold and a benchmark. The benchmark is a reference point used to define a high level of performance, while the achievement threshold is the minimum level of hospital performance required to receive achievement points. CMS has empirically established benchmarks and achievement thresholds using national data from a prior baseline period. Final performance standards and benchmarks can be found in Table 3 of the Hospital VBP Final Rule and are also provided in the table on the next page.

Final Achievement Thresholds and Benchmarks for the Fiscal Year 2013 Hospital Value-Based Purchasing Program Measures

Clinical Process of Care Measures			
Measure ID	**Measure Description**	**Performance Standard (Achievement Threshold)**	**Benchmark**
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.6548	0.9191
AMI-8a	Primary Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival	0.9186	1.0
HF-1	Discharge Instructions	0.9077	1.0
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	0.9643	1.0
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient	0.9277	0.9958
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9735	0.9998
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9766	1.0
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9507	0.9968
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6:00 a.m. Postoperative Serum Glucose	0.9428	0.9963
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.9500	1.0
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	0.9307	0.9985
SCIP–Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period.	0.9399	1.0
Patient Experience of Care Measures			
Measure ID	**Measure Description**	**Performance Standard (Achievement Threshold)**	**Benchmark**
HCAHPS	Communication with Nurses	75.18%	84.70%
	Communication with Doctors	79.42%	88.95%
	Responsiveness of Hospital Staff	61.82%	77.69%
	Pain Management	68.75%	77.90%
	Communication About Medicines	59.28%	70.42%
	Cleanliness and Quietness of Hospital Environment	62.80%	77.64%
	Discharge Information	81.93%	89.09%
	Overall Rating of Hospital	66.02%	82.52%

38. How will a hospital's performance for each measure be scored?

First, a hospital will earn 0-10 points for **achievement** based on where its performance for each measure falls relative to (a) the achievement threshold (performance at the 50th percentile) and (b) the benchmark (performance at the mean of the top decile).

Second, a hospital will earn 0-9 points based on its performance **improvement** on the measure compared with the baseline period for the measure. (CMS believes that a hospital should not receive full credit—that is, the maximum ten points—for improving.)

For each measure, CMS will compare a hospital's achievement and improvement scores. Hospitals will then be awarded their **highest score** for each measure, representing either achievement or improvement on that measure. These scores will be used for calculating a hospital's total performance score.

39. How will a hospital's total performance score be calculated?

A hospital's total performance score will be calculated by taking the sum of the hospital's weighted domain scores. (See Question 27 for more information about the methodology of the Hospital VBP Program.)

A hospital's Clinical Process of Care domain score will be calculated as the percentage of possible points scored on applicable clinical process measures multiplied by 100. The Patient Experience of Care domain score will be calculated as the sum of the HCAHPS base score and the HCAHPS Consistency score. For Fiscal Year 2013, hospitals' domain scores will be weighted at 70% for Clinical Process of Care and 30% for Patient Experience of Care. For more information on the performance scoring methodology, please see the following explanations and the Hospital VBP Final Rule.

In FY 2013, a hospital's total performance score will be based on all Clinical Process of Care domain measures that apply to the hospital (meaning, the measures that count toward the financial incentive for which the hospital submitted data and for which it had a sufficient number of cases) along with the Patient Experience of Care domain dimensions.

Calculating the Clinical Process of Care Domain Score
For the Clinical Process of Care domain, the number of measures applicable to each hospital will vary depending on the services the hospital provides. (For example, some hospitals may not perform percutaneous coronary interventions; therefore, this measure would not apply to them.) Points earned for each measure will be added to determine the total earned points for the Clinical Process of Care domain:

Total **Earned** Clinical Care Domain Points	=	Sum of Points Earned (higher of either achievement or improvement) Across All Reported Measures

Each hospital will also have a corresponding set of total possible points for the Clinical Process of Care measures, calculated as follows:

Total **Possible** Clinical Care Domain Points	=	Total Number of Measures Reported by Hospital	x	10 Points

The hospital's total domain score for the Clinical Process of Care measures will be calculated as follows:

$$\text{Total Clinical Care Domain Performance Score} = \frac{\text{Total } \mathbf{Earned} \text{ Clinical Care Domain Points}}{\text{Total } \mathbf{Possible} \text{ Clinical Care Domain Points}} \times 100$$

Calculating the Patient Experience of Care Domain Score
The Patient Experience of Care domain score consists of two components.

In the first component, HCAHPS survey responses for each hospital will be used to calculate an achievement and an improvement score for each of the eight dimensions used in Hospital VBP:

- Nurse communication
- Doctor communication
- Cleanliness and quietness
- Responsiveness of hospital staff
- Pain management
- Communication about medications
- Discharge information
- Overall rating

For each of these eight HCAHPS dimensions, the higher of the achievement or improvement score will be added to determine the total earned HCAHPS base score:

Total **Earned** HCAHPS Base Score	=	Sum of Points (higher of either achievement or improvement) for Each of Eight HCAHPS Dimensions

The second component of the Patient Experience of Care domain score is the Consistency score. This score recognizes consistent achievement across all eight HCAHPS dimensions and rewards hospitals for performing above the median on all dimensions. CMS will award Consistency points proportionately based on the single *lowest* of a hospital's eight HCAHPS dimension scores during the performance period compared to the achievement threshold for that specific HCAHPS dimension. This is defined as a fraction of the distance between the achievement threshold (50^{th} percentile in the baseline period) and the floor (0^{th} percentile in the baseline period, or the worst-performing hospital).

If all eight of a hospital's dimension scores during the performance period are at or above the 50^{th} percentile achievement threshold in the baseline period, then that hospital will earn all 20 Consistency points. If the lowest score a hospital receives on an HCAHPS dimension is at or below the floor of hospital performance on that dimension during the baseline period, then that hospital earns zero Consistency points. Otherwise, Consistency points are awarded proportionately according to the distance of the performance period score between the floor and the achievement threshold.

To calculate the Consistency score, CMS defines the **lowest dimension score** as the lowest value across the eight HCAHPS dimensions using the following formula:

$$\text{Lowest Dimension Score} = \frac{\text{Hospital's Performance Period Score} - \text{Floor}}{\text{Achievement Threshold} - \text{Floor}}$$

The Consistency score is then calculated as follows, **with a minimum score of 0 and a maximum score of 20**:

$$\text{Consistency Score} = 20 \times \text{Lowest Dimension Score} - 0.5$$

A hospital's total Patient Experience of Care domain performance score is then calculated as follows:

$$\text{Total HCAHPS Performance Score} = \text{Total } \textbf{Earned} \text{ HCAHPS Base Score} + \text{Consistency Score}$$

Finally, a hospital's Total Performance Score for the FY 2013 Hospital VBP Program is then calculated as follows:

$$\text{Total Performance Score} = (0.70 \times \text{Total Clinical Process of Care Domain Performance Score}) + (0.30 \times \text{Total Patient Experience of Care Domain Performance Score})$$

40. Is there an incentive for high-performing hospitals that already score higher than national benchmarks to perform poorly in the short term so that they can win improvement points and receive higher payments?

CMS expects all Medicare hospitals to provide high-quality care to their patients whether they are included in the Hospital VBP Program or not. CMS does not believe that high-achieving hospitals would have any incentive to lower their performance in order to win improvement points in the Hospital VBP Program.

Based on the structure of Hospital VBP, it is difficult to envision a scenario in which a high-performing hospital would earn more points on a measure by intentionally lowering performance during a baseline period and increasing performance during the performance period versus simply maintaining high performance during the baseline period and seeking to maintain or improve on that performance during the performance period.

CMS will closely monitor and evaluate the impacts of the Hospital VBP Program on the quality of care provided to Medicare beneficiaries.

41. Why aren't consistency points used for both the Clinical Process and Patient Experience domains?

CMS believes that consistency points convey to hospitals that all HCAHPS dimensions should be improved and provide an incentive to hospitals to bring lagging scores up to at least the achievement threshold. Providing incentives for an entire group of measures is consistent with promoting wider systems changes within hospitals to improve quality.

CMS will consider developing consistency points in the Clinical Process domain in the future. However, CMS notes that applying consistency points in that domain would be challenging. Because all hospitals report all dimensions of the HCAHPS survey, CMS can reward consistency across all dimensions. Applying consistency points to the Clinical Process of Care domain when different numbers of measures might apply to different hospitals may result in unfair distributions of consistency points.

42. Why does the Patient Experience domain garner 30 percent of the Total Performance Score?

While CMS recognizes that patient experience of care as reported through patient surveys is inherently subjective, CMS also believes that delivering high-quality, patient-centered care requires careful consideration of the patient's experience. HCAHPS surveys provide a robust, reliable measure of this experience.

**43. 
How will data such as the Central Line Infection measure, which is reported through the National Healthcare Safety Network, be calculated into Hospital VBP scores?**

At this time, Central Line-Associated Blood Stream Infection (CLABSI) isn't currently a measure captured in the Hospital VBP Program.

44. NEW How does CMS assess hospitals' achievement for FY 2013 Hospital VBP?

To measure achievement, the Centers for Medicare & Medicaid Services (CMS) will assess how much each hospital's performance during the performance period differs from the performance of all other hospitals during the baseline period. CMS will only award achievement points if a hospital's performance during the performance period exceeds the 50th percentile of all hospitals' performance during the baseline period. The 50th percentile is defined by CMS as the "threshold."

45. NEW How does CMS assess hospitals' improvement for FY 2013 Hospital VBP?

Improvement points are calculated by determining the hospital's performance on a measure during the entire baseline period compared to the entire performance period. Hospitals' scores are not added based on quarterly performance, but are calculated based on their applicable patients during the entire period. Scoring is not based on hospitals' placement in measure quartiles, but rather on relative achievement and improvement over time.

Further information on quality measures in Hospital IQR and Hospital VBP, including mortality rates, is available on QualityNet and in the Hospital Inpatient VBP Final Rule and the CY 2012 OPPS/ASC Final Rule. We note that CMS is statutorily prohibited from using selected measures of readmissions for the Hospital VBP Program. We also note that, while Hospital VBP measures are selected from Hospital IQR's measure set, the time periods used for Hospital VBP are different from those posted on Hospital Compare.

46. NEW How does CMS calculate hospitals' HCAHPS consistency scores?

Consistency Points (which range from 0-20) provide an added incentive for hospitals to achieve at least median performance on all eight dimensions of the Patient Experience of Care domain. Consistency Points are awarded based on the single lowest of a hospital's eight dimensions. A hospital will be awarded the maximum 20 Consistency Points when its performance on each dimension during the performance period equals or exceeds each dimension's achievement threshold. More information—including helpful graphics that illustrate Consistency Points—can be found in the file located at: http://www.cms.gov/Hospital-Value-Based-Purchasing/Downloads/HospVBP_ODF_072711.pdf

47. NEW How will mortality measures be scored for the FY 14 Hospital VBP Program?

Mortality measures will be scored similarly to the Clinical Process of Care measures and HCAHPS dimensions, though we note that lower scores on mortality measures are better. CMS cannot comment on measures under consideration for the FY 2015 Program. We expect to display the 2013 IPPS rule in April 2012.

48. Will the one additional mortality factor be for year two (FY 14) of the program?

CMS has finalized three 30-day mortality measures (MORT-30-AMI, MORT-30-HF, and MORT-30-PN) for use in the FY 2014 Hospital VBP Program (year two). CMS suspended use of the HAC and AHRQ measures in the CY 2012 OPPS/ASC Final Rule, so the mortality measures are the only finalized measures in the Outcomes domain for FY 2014.

49. How will monthly variances in HCAHPS scores be calculated for a quarterly and yearly score, and what sort of impact will these scores have on reimbursement?

The Hospital VBP Program does not calculate HCAHPS scores on a monthly basis. Rather, hospitals' HCAHPS scores are added across the entire performance period. For FY 2013, the performance period runs for 9 months, so yearly scores are not a component of the Total Performance Score. 30 percent of a hospital's total performance score will be based on the Patient Experience of Care domain.

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Translating Scores into Payments

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50. How will a hospital's value-based incentive payment be calculated?

Section 1886(o)(6)(B) of the Social Security Act defines the value-based incentive payment amount for each discharge in a fiscal year as the product of (1) the hospital's base operating Diagnosis-Related Group (DRG) payment amount for the discharge during that fiscal year, and (2) the hospital's value-based incentive payment percentage during that fiscal year.

The SSA also requires that, for FY 2013, Hospital VBP incentive payments will be paid out of the 1.0 percent reduction to the base operating DRG payments for each discharge. This funding is based on the requirement that the total amount available for value-based incentive payments for all hospitals for a fiscal year must be equal to the total amount of reduced payments for all hospitals, as estimated by the HHS Secretary.

In specifying the value-based incentive payment percentage, the Secretary must ensure that (1) the percentage is based on the hospital's performance score and (2) that, as estimated by the Secretary, the total amount of value-based incentive payments available to all hospitals in a fiscal year is equal to the total amount of reduced payments for all participating hospitals for that fiscal year. Therefore, CMS will use a hospital's total performance score so that the estimated FY 2013 value-based incentive payments for all hospitals are equal to 1.0 percent of the estimated FY 2013 base operating DRG payment amounts for all hospitals.

51. How does the performance score get translated into the value-based incentive payment?

To translate a hospital's total performance score into the value-based incentive payment earned by that hospital, CMS will use a mathematical formula, the linear exchange function, to calculate the value-based incentive percentage. CMS will set the slope of the linear exchange function for FY 2013 so that the estimated total value-based incentive payments to all participating hospitals for FY 2013 are equal to 1.0 percent of the estimated total base operating DRG payment amounts for all hospitals for FY13.

CMS will then calculate the value-based incentive payment amount for each discharge by multiplying (1) the base operating DRG payment amount for the discharge for the hospital by (2) the value-based incentive payment percentage for the hospital. Finally, since the total performance scores are based on hospital performance during the entire performance period, CMS will not be able to calculate the exact slope of the exchange function until after the performance period has ended.

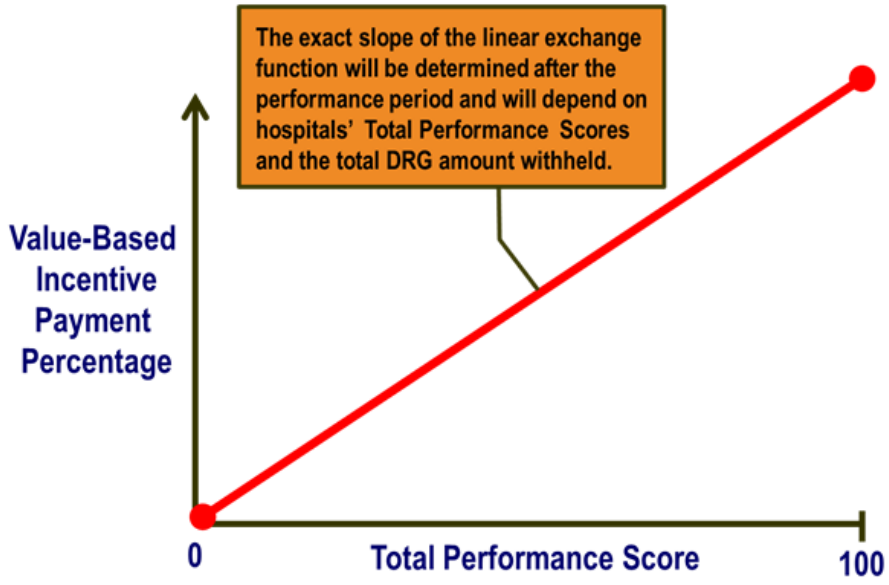

Figure 1. Hospital VBP Linear Exchange Function

52. Should greater incentives be provided to lower-performing hospitals, particularly during the early stages of the Hospital Value-Based Purchasing Program?

Using the linear exchange function provides all hospitals the same marginal incentive to continually improve. This is also the simplest and most straightforward of the mathematical exchange functions discussed in the Final Rule. (For more detail about this, you can read the Final Rule for the FY 2013 Hospital VBP program online at http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf.)

CMS believes it is prudent to examine the experience and data from the initial implementation of the program before considering increasing the incentives to lower-performing hospitals. CMS also notes that increasing incentives to lower-performing hospitals would result in decreased incentives for higher-performing hospitals due to the Social Security Act's budget neutrality requirement.

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Public Reporting

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53. What hospital performance information gathered through the Hospital Value-Based Purchasing Program will be made available to the public?

The following information about a hospital's performance determined through Hospital VBP will be made available to the public:

1. The hospital's performance on each measure that applies
2. The hospital's performance with respect to each condition or procedure
3. The hospital's total performance score

Information collectively describing all hospitals participating in the Hospital VBP Program will be posted periodically on the *Hospital Compare* website, including:

1. The number of hospitals receiving value-based incentive payments under the program, as well as the range and amount of these value-based incentive payments
2. The number of hospitals receiving less than the maximum value-based incentive payment available for that fiscal year and the range and amount of these payments

Hospital Compare is online at http://www.hospitalcompare.hhs.gov.

54. Will CMS be posting the mortality, process, and HCAHPS measures to *Hospital Compare* using the same time periods that will be used for FY 14 of Hospital VBP (e.g., 12-month timeframes versus the usual 36-month timeframe for reporting mortality measures)?

We will address data posting on *Hospital Compare* in future rulemaking. We intend to publish measures data using the time periods finalized for use in Hospital VBP.

55. Will *Hospital Compare* begin to display a view of the current baseline data (already submitted) and the performance period data? This is important because Hospital VBP uses three quarters of data for assessing FY 13 performance, rather than the four-quarter timeframe usually reported for quality measures on the *Hospital Compare* website.

CMS intends to make proposals related to performance information display on *Hospital Compare* in the FY 2013 IPPS rule.

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Appeals

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56. Does a hospital have the ability to appeal its performance assessment?

Yes. In the future, CMS plans to propose an appeals process based on Section 1886(o)(11) of the Social Security Act.

57. What is the deadline for a hospital to appeal its performance assessment?

This appeal process deadline will be proposed in future regulation.

58. Please provide information on the Review and Corrections Report and the Review and Correction Period. I am especially interested in what can and cannot be corrected. Please provide examples relevant to hospitals changing CMS Certification Numbers (CCN) or hospitals merging to start sharing a CCN.

CMS provided details on the FY 2013 Review and Corrections period in the Hospital Inpatient VBP Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf) and the Calendar Year (CY) 2012 Outpatient Prospective Payment System (OPPS) / Ambulatory Surgical Center (ASC) Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf). We refer readers to those rules for additional detail. We intend to make additional proposals on review and corrections in the FY 2013 Inpatient Prospective Payment System (IPPS) / Long-term Care Hospitals (LTCH) rule.

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Information CMS Shares with Hospitals

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59. How do hospitals find out what their Hospital VBP "score" is?

At least 60 days before October 1, 2012, CMS will notify each hospital participating in Hospital VBP of its estimated value-based incentive payment for each patient discharge in Fiscal Year (FY) 2013 through that hospital's QualityNet account. By November 1, 2012, CMS intends to notify hospitals of their value-based FY 2013 incentive payment percentage for each FY 2013 discharge. The value-based incentive payment will depend on each hospital's Total Performance Score.

60. When will we learn how a hospital's score gets translated into something meaningful (i.e., a payment adjustment)?

At least 60 days before October 1, 2012, CMS will notify each hospital participating in Hospital VBP of its estimated value-based incentive payment for each patient discharge in FY 2013 through that hospital's QualityNet account. By November 1, 2012, CMS will notify hospitals of their value-based incentive payment percentage for each FY 2013 discharge. The exact value-based incentive payment will depend on each hospital's Total Performance Score.

61. When and how will we know our scores for the 9-month performance period versus 9-month baseline period with CMS adjustments applied?

We intend to provide detailed scoring reports to all participating hospitals by November 1, 2012. Those reports will include each hospital's performance information on all applicable measures from both the baseline period and the performance period.

62. At what intervals will the VBP scoring information be released to hospitals and *Hospital Compare*?

CMS plans to release scoring data information to hospitals on a quarterly basis (for a 30-day preview period) and then post results on *Hospital Compare*.

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Dry Run Reporting

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63. When will the Simulated Reports be updated going forward?

We do not anticipate updating the Simulated Reports because they are the product of a one-time program simulation. In future program years, however, CMS will provide hospitals with their actual performance scoring reports that they may use to assess their performance across program years.

64. Will the Simulated Hospital VBP Program Reports be available just this one time prior to 2013, or will they be available multiple times? How can we get the reports?

We do not anticipate updating the Simulated Reports because they are the product of a one-time program simulation. In future program years, however, CMS will provide hospitals with their actual performance scoring reports that they may use to assess their performance across program years.

65. Will these reports be provided on an ongoing basis?

We do not anticipate updating the Simulated Reports because they are the product of a one-time program simulation. In future program years, however, CMS will provide hospitals with their actual performance scoring reports that they may use to assess their performance across program years.

66. What date will the individual hospital Dry Run Reports be available on QualityNet?

Hospital-specific Dry Run reports have been distributed via My QualityNet on February 29, 2012 to active, registered QualityNet users with the QIO Clinical Whse Feedback Reports role. From the My QualityNet page, the registered QualityNet user can click on "Send/Receive" in the "Exchange Files" area to retrieve the Dry Run report from the inbox.

67. What will the Simulated Report look like?

The Simulated Report will feature this specific information:

1. Data based on a baseline period of April 1, 2008 to December 31, 2008 and a performance period of April 1, 2010 to December 31, 2010
2. Your hospital's estimated incentive payment percentage, based on the baseline and performance periods noted above
3. Your hospital's Total Performance Score and a comparison to national and state Total Performance Scores
4. Your hospital's scores for the Clinical Process of Care domain and the Patient Experience of Care domain

5. Your hospital's individual Clinical Process measure performance and scores
6. Your hospital's individual Patient Experience dimension performance and scores
7. Your hospital's individual Patient Experience of Care domain Consistency score
8. Detailed explanations of every section of the Simulated Report

CMS will provide complete Simulated Reports to hospitals believed to be eligible for the FY 2013 Program based on reporting data from the baseline and performance periods noted above. In addition, CMS will provide abbreviated reports to non-eligible hospitals, displaying performance and scores for areas where they have met the eligibility requirements and using "n/a" to indicate program areas where they were not eligible.

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Special Information for Critical Access Hospitals

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68.  We are a Critical Access Hospital (CAH). Will the Hospital VBP Program address items specific to us?

CAHs are designated under Section 1820(c) of the Social Security Act. Therefore, consistent with Section 1886(o)(1)(C)(i) of the Social Security Act, which limits participation in the Hospital VBP Program to subsection (d) hospitals, CAHs are ineligible to participate in the Hospital VBP Program.

69.  Is there any news about the implementation of the Value-Based Purchasing (VBP) demonstration programs for Critical Access Hospitals and hospitals that do not have enough cases or measures to participate in the larger VBP program?

CAHs and hospitals with insufficient cases are excluded from the Hospital VBP program based on statutory mandate. Congress must approve any statutory modifications to include these hospitals into a VBP program. We encourage non-eligible and excluded hospitals to get more information about the Hospital VBP Program and Dry Run process through our website at http://www.cms.gov/hospital-value-based-purchasing.

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Miscellaneous/Other Questions

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70. What role do you see for home care agencies?

We encourage home care agencies to collaborate with eligible hospitals to coordinate and improve quality of care. The Hospital VBP program's eligibility is statutorily limited to eligible hospitals. Currently, Home Health services fall under the CMS quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation and the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) (76 FR 628 through 646) that links payment to performance.

71. Is this program just another treadmill? In other words, is the expansion of processes, areas covered, and other measures in future years just going to water down the impact of poor performance in any one (or later several) area(s) if off-set by improving performance in other areas?

CMS will use Monitoring and Evaluation processes that will help determine what program measures and/or performance areas are approaching a topped out status or no longer have the support of the National Quality Forum.

72. We are a new facility. We will begin submitting data starting the first quarter of 2012. How will Value-Based Purchasing apply to us?

As discussed in the Hospital Inpatient VBP Final Rule, if your facility treats enough applicable patients to meet the finalized case and measure minimums for the FY 2013 Program, your facility will be included for that program year. If your facility does not treat enough applicable patients to meet the 10 cases and 4 measures minimum within the Clinical Process of Care domain and 100 HCAHPS surveys within the Patient Experience of Care domain, your facility will not be included in the FY 2013 Program. We note that because your facility was not open during the FY 2013 baseline period, your points will be awarded based on achievement only.

73. How will a small-volume hospital be measured for performance and reimbursement?

As discussed in the Hospital Inpatient VBP Final Rule, small hospitals will be measured for performance and reimbursement according to the same criteria as large hospitals, as long as the small facilities meet the finalized minimum case and measure criteria.

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For More Information

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74. How can I learn more about the Hospital VBP Program?

Visit CMS' Hospital VBP website at http://www.cms.gov/hospital-value-based-purchasing for the latest information for hospitals. You can also refer to CMS' Medicare Learning Network article, "Fact Sheet: Hospital Value-Based Purchasing Program" online at http://www.cms.gov/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.

More information for hospitals about data submission and transmission of performance reports is available on the QualityNet portal at http://www.qualitynet.org.

Questions not addressed on these websites can be submitted to CMS at HospitalVBP@cms.hhs.gov. CMS will update this FAQ document regularly to address new questions received.

75. Can we receive copies of the slides from the February 28, 2012 National Provider Call?

The slides are available at http://www.cms.gov/Hospital-Value-Based-Purchasing/Downloads/HVBPNPCSlides022812.pdf.

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