

HOSPITAL VALUE-BASED PURCHASING PROGRAM ADDS SCORING FOR HEALTH DISPARITIES

In the **FY 2024 IPPS Final Rule** (the “Final Rule”), the Centers for Medicare & Medicaid Services (“CMS”) incorporated certain social risk factors into the Hospital Value-Based Purchasing (“VBP”) Program (“the Program”). Set to begin in the FFY 2026 payment year, CMS will be using data on inpatient stays **from January 1, 2024 through December 31, 2024**.

BACKGROUND

Congress mandated the Hospital VBP Program in 2010 to reward acute care hospitals for the quality of care provided in the inpatient setting. The Program reduces participating hospitals’ base operating DRG payments by 2% each fiscal year and uses this amount to fund value-based incentive payments to hospitals based on their performance on certain performance measures, including the clinical process of care, patient experience of care, patient safety, efficiency and cost-reduction, health care-associated infections and other outcome measures. CMS adjusts a hospital’s Medicare payment based on a total performance score that reflects, on a measure-by-measure basis, how well the hospital performs on the performance measures in comparison to all hospitals, or how much the hospital improves its own performance compared to its performance during a prior baseline period.

Medicare providers and other stakeholders have long argued that VBP programs such as the Hospital VBP Program unfairly penalize hospitals that treat greater proportions of disadvantaged patients. Over the last several years, a growing body of evidence supports stakeholders’ contention that these programs are inequitable and financially penalize safety-net systems and systems that care for a higher proportion of disadvantaged patients. For instance, an analysis published by the **Harvard School of Public Health** found that hospitals that treat the most low-income patients had their payment rates reduced by 0.09% under the Program, whereas hospitals with the fewest low-income patients received an average bonus of 0.60%. As a result, many stakeholders have advocated for reducing this inequity by adjusting for social risk factors in CMS’s value-based payment policies.

Acknowledging that dual enrollment in Medicare and Medicaid is a strong predictor for low-income and poorer health outcomes, CMS will now award bonus points known as the Health Equity Adjustment (“HEA”) to a hospital’s Total Performance Score for the proportion of dual-eligible patients the hospital serves. The Final Rule also introduces an “Underserved Multiplier,” which CMS defines as the “number of Inpatient stays for patients with dual eligibility status from two years prior divided by Total Medicare Inpatient Stays.” For example, when this methodology becomes effective in 2026, CMS will be using the data on inpatient stays from January 1, 2024 through December 31, 2024, to determine the Underserved Multiplier number for payment year 2026. The HEA will be the product of the sum of the points awarded to a hospital for each domain multiplied by the Underserved Multiplier.

CMS ACTIONS TO ADDRESS STAKEHOLDER CONCERNS

In the Final Rule, CMS attempts to address the aforementioned concerns, finalizing a solution that is designed to award more points to hospitals that serve greater percentages of underserved populations and have higher quality performance. However, it remains to be seen whether the agency’s changes to the Program go far enough to meaningfully account for all relevant health and social risk factors.

While this is a step forward, CMS’s new HEA may still fall short in properly accounting for other health equity factors that may negatively impact performance under the Program and are not within the hospital’s control. CMS has stated that it will only award bonus points for dual eligibles who are eligible for the full Medicaid benefit, identified as patients with dual eligibility codes in the Medicare Beneficiary Summary file. The decision to use that file as the sole source for determining whether the HEA is warranted potentially omits a large number of disadvantaged patients, as it does not capture all relevant socio-economic factors.

PRACTICAL TAKEAWAYS

- CMS acknowledges that hospitals that serve a disproportionate number of individuals with low income or other social inequities have received lower payments in the Program than other hospitals that serve wealthier and less disadvantaged individuals.
- However, the HEA as currently implemented may fall short of its intended goal without factoring in additional social determinants of

health into the adjustment.

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