

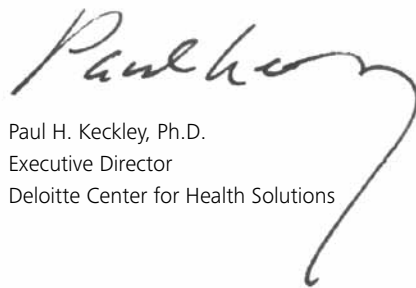
Issue Brief:

Value-based Purchasing: *A strategic overview for health care industry stakeholders*

Foreword

The concept of “value” in health care is widely discussed among industry stakeholders; rarely, however, is it defined the same way by the individual health care sectors. The Patient Protection and Affordable Care Act (PPACA) of 2010 mentions “value” 214 times.¹ PPACA’s payment reform provisions, including value-based purchasing, accountable care organizations (ACOs), bundled payments, and the medical home, target improvements in quality and efficiency at a time when health care costs comprise 23 percent of the federal budget. Medicare – the biggest cost commitment – is currently 16 percent of the federal budget, and projected to increase to 20 percent in 2016.²

Value-based purchasing (VBP) in the context of the new health care reform legislation is the focus of this Issue Brief. We believe that payers and consumers will embrace VBP as a central feature in assessing their relationships with providers.



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Definition: what is value-based purchasing in health care delivery?

In the health care delivery system, VBP is a payment methodology that rewards quality of care through payment incentives and transparency.³ In health care, value can be broadly considered to be a function of quality, efficiency, safety, and cost. In VBP, providers are held accountable for the quality and cost of the health care services they provide⁴ by a system of rewards and consequences, conditional upon achieving pre-specified performance measures.⁵ Incentives are structured to discourage inappropriate, unnecessary, and costly care.

Critical to VBP is standardized, comparative, and transparent information on patient outcomes; health care status; patient experience (satisfaction); and costs (direct, indirect) of services provided. It is a departure from the Medicare fee-for-service (FFS) payment system, which rewards excessive, costly, and complex services, rather than quality, and contributes to the unsustainable costs of health care.^{6, 7, 8} VBP payment reform is expected to reduce Medicare spending by approximately \$214 billion over the next 10 years;⁹ nearly 75 percent of beneficiaries participate in the current FFS payment model¹⁰ and 40 percent of the average hospital payer mix is Medicare.¹¹ With this substantial volume of Medicare business at hospitals, VBP has significant implications for health care organizations.



Glossary

Term/Acronym	Definition
ACE	Acute Care Episode
ACO	Accountable Care Organization
CABG	Coronary Artery Bypass Graft
CAHCPS	Consumer Assessment of Health Care Providers and Systems
CCHIT	Certification Commission for Health Information Technology
CMS	Centers For Medicare and Medicaid Services
Demo	Demonstration
DRG	Diagnosis Related Group
EHR	Electronic Health Record
ESRD	End Stage Renal Disease
FFS	Fee For Service
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HHS	Department of Health and Human Services
MI	Myocardial Infarction
P4P	Pay for Performance
P4R	Pay for Reporting
PPACA	Patient Protection and Affordable Care Act (enacted into law March 23, 2010)
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
SNF	Skilled Nursing Facility
VBP	Value-based Purchasing

Background: VBP in PPACA

Although recently enacted into law under PPACA, VBP has been in development for years.^{12, 13, 14}

- Medicare Modernization Act (MMA) of 2003:** Congress commissioned the Institute of Medicine (IOM) to “identify and prioritize options to align performance to payment in Medicare.” The IOM reports provided the rationale to reconfigure the U.S. health care payment system, supporting a “pay for performance” (P4P) approach.¹⁵
- Deficit Reduction Act (DRA) of 2005 Section 5001(b):** This act required HHS to develop a plan to implement a VBP program for Medicare payment for subsection (d) hospitals, beginning with FY 2009. The Medicare Hospital VBP program would be built on the current Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program and be budget-neutral.¹⁶
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 Section 131(d):** This act required HHS to develop a VBP transition plan for providers receiving Medicare payments. HHS submitted this report to Congress in December 2008 detailing a draft transition plan to a Medicare VBP program for physicians and other professional services, as well as the design issues under consideration.¹⁷

Implementing VBP: lessons from previous VBP programs

The Centers for Medicare and Medicaid Services (CMS) began implementing VBP pilots in 2003.^{18, 19} Commercial health plans have followed suit with versions of VBP that align consistently with Medicare goals for better care, lower costs, and improved efficiency.

Goals for CMS' VBP Initiatives³

- Improve clinical quality
- Address problems of underuse, overuse, and misuse of services
- Encourage patient-centered care
- Reduce adverse events and improve patient safety
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in structural components and the re-engineering of care processes system-wide
- Make performance results transparent to and useable by consumers
- Avoid creating additional disparities in health care and work to reduce existing disparities.

These CMS pilots may be grouped in three categories:²⁰

- **Pay-for-reporting (P4R) programs** – a provider is incentivized to report information for public consumption.
- **Pay-for-performance (P4P) programs** – a provider is incentivized to achieve a targeted threshold of clinical performance, typically a process or outcome measure associated with a specified patient population.
- **Pay-for-value programs** – typically, these are specific to a provider setting (i.e., hospital inpatient or outpatient, physician, home health, skilled nursing facility [SNF], and dialysis) and linked to both quality and efficiency improvements.

Figure 1 provides a summary of notable CMS VBP initiatives.



Figure 1: CMS' VBP Initiatives^{21, 22, 23, 24, 25, 26, 27}

Initiative	Provider Type	Incentive	Implementation Dates
Physician Group Practice Demo	Group practices with a minimum of 200 physicians	Physician groups share up to 80 percent of savings if per capita spending is <2 percent of local growth rate	Began April 2005; end date March 31, 2010
Premier Hospital Quality Incentive Demonstration	Hospitals	Bonus payments for high absolute or relative performance as well as improvement	October 2003-September 2009
Medicare Care Management Demo	Small-to-medium size (up to 20 physicians per practice) primary care physician groups	Initial payment for reporting; annual payment for performance (achieving minimum HEDIS scores); bonus payment for using Certification Commission for Health Information Technology (CCHIT)-certified EHR	Data aggregation began 2006; performance period began July 1, 2007; end date June 30, 2010
Physician Quality Reporting Initiative (PQRI) Incentives Program	Individual physicians to whom PQRI measures apply	Bonus for reporting measures (not performance-based); satisfactory reporters earn 1.5 percent of total allowed charges for covered services during reporting period	Voluntary reporting began 2006; incentives for reporting began July 2007; end date December 31, 2010
Hospital VBP Plan to Congress	All inpatient Prospective Payment System (PPS) hospitals	Currently, reporting hospitals receive full Annual Payment Update (APU); under VBP plan, incentive payments calculated based on improvement and attainment formula	Payment incentive for voluntary reporting began 2005; report to Congress presented in 2007 and transition plan delivered December 2009; plan finalization ongoing
Nursing Home VBP Demo	Nursing homes	Top 20 percent of nursing homes will qualify for incentives derived from savings due to avoidable hospitalizations and SNF stays	Began July 1, 2009; ongoing
Home Health P4P Demo	Certified home health agencies	Savings resulting from reduced use of Medicare services will be shared with top 20 percent of home health agencies (HHAs) based on quality metrics	January 2008-December 2009

For CMS' hospital VBP model in PPACA, core clinical and patient satisfaction measures will be weighted and combined into one composite VBP score for each hospital.²⁸ The clinical quality measures will be based on Medicare's P4R initiative, Hospital Inpatient Quality Reporting Program (formerly RHQDAPU), as reported on the Hospital Compare website (see <http://www.hospitalcompare.hhs.gov> for examples). The patient satisfaction measures (including timeliness of appointment, communication with provider, and interaction with office staff) will be based on the hospital Consumer Assessment of Health Care Providers and Systems (CAHCPS) survey.^{29, 30} Measures evaluating care process, efficiency, and care coordination may be added at a later time.³¹ Performance standards based on past experience with measures, historical averages, and improvement rates will be established by HHS.³²

CMS has undertaken several P4P and pay-for-value pilots and demonstrations; preliminary results look promising for some. The Physician Group Practice (PGP) Demonstration resulted in nearly 80 percent (\$25.3 million) in total Medicare savings being awarded to half of the participating groups in the first three years.^{33, 34} CMS also reported substantial improvements (an average total increase of 15.8 percentage points) in composite quality scores (CQS) for acute myocardial infarction (MI), coronary artery bypass graft (CABG), heart failure, pneumonia, and hip/knee replacements by the end of year three in the Hospital Pay-for-Performance: Premier Demonstration. Quality improvement continued into the fourth year, resulting in a total of \$36.5 million in performance incentives awarded to participating hospitals.^{35, 36, 37}

To date, relatively few studies have evaluated the effectiveness of each of these initiatives.^{38, 39} One PPACA provision created the Center for Medicare and Medicaid Innovation within CMS to oversee the development and implementation of CMS' VBP pilots and formally evaluate them starting in 2011.⁴⁰ With a \$10 million budget over 10 years, the Innovation Center will invest in new payment strategies to identify savings in the delivery system.⁴¹

Looking ahead: VBP implementation in health care reform

PPACA (Section 3001 as modified by sec. 10335) requires that a final VBP model design be determined by 2012. Hospitals serving Medicare beneficiaries will be eligible to receive incentive payments in 2013 for patients with high-volume conditions (i.e., chronic heart failure, acute MI, pneumonia, surgeries, and health care-associated infections). Incentive payments for achieving performance targets or demonstrating improved quality and efficiency will be derived from progressive reductions in Medicare Diagnosis Related Group (DGR) reimbursements, commencing in 2013.⁴² Other health care delivery settings – including Ambulatory Surgery Centers (ASCs), HHAs, and SNFs – and physician reimbursement will follow shortly thereafter. By January 2016, PPACA also mandates VBP programs for psychiatric hospitals, PPS-exempt oncology centers, hospice programs, long-term care hospitals and rehabilitation hospitals. Hospitals with lower volumes, such as critical access hospitals, will participate in a parallel program starting within two years.⁴³ Hospitals not meeting certain minimum standards will be excluded from the incentive scheme.⁴⁴ Otherwise, participation is mandatory for all other hospitals serving Medicare members.^{45, 46}

The quality measures incorporated in the final CMS model and their proportion of the total VBP score form the basis for measuring performance and awarding financial incentives. A recent study by VHA Inc. revealed that hospital VBP scores were lower than the threshold at which they qualify for financial incentives (53 vs. 70), potentially putting hospitals at risk for losing millions of dollars. The low scores were attributed to low patient experience scores, which comprised 30 percent of the total VBP score.⁴⁷ Patient-centered care is a cornerstone of VBP and emphasis on customer service and satisfaction will be a success factor in CMS' VBP program.⁴⁸ An assessment of an organization's baseline performance against established external and internal quality benchmarks is critical to becoming favorably positioned for financial incentives.

Currently, Medicare's various reporting programs include numerous unique measures that are relatively unaligned and non-standardized across the programs,⁴⁹ complicating interpretation of the measures.⁵⁰ Lack of correlation between clinical outcomes and patient experience, and the profound impact that measure type and relative weighting have on a hospital's total performance,⁵¹ underscore the need for providers to engage in defining the quality measures ultimately included in CMS' models. CMS is required to consult stakeholders as it develops the various VBP models; this provides an opportunity to influence the selection of relevant and impactful measures.⁵² Aligned and standardized measures across settings will be necessary for successful implementation of VBP under the current FFS program.⁵³

In addition to improving quality and outcomes, managing expenses is also a fundamental part of VBP. As Medicare payments are reduced for all providers, cost containment will become increasingly important for survival, particularly for providers not achieving performance targets. Successful strategies to curtail costs may entail a multi-stakeholder approach within an organization to identify ways to reduce waste and non-labor expenses without comprising quality.⁵⁴

Commercial health plans' response to VBP and other payment reforms

VBP is among several PPACA payment reform changes. In many cases, commercial health plans have adopted their own versions of payment reform, including penalties for hospital-acquired conditions (HAC), infections, and preventable readmissions. Health plans have incorporated bundled payments (including medical homes and ACEs),⁵⁵ Medicare Advantage star ratings, and ACOs.⁵⁶ Initiatives such as the Brookings-Dartmouth ACO Learning Network explore ways of fully integrating care and coordinating clinical and financial accountability. (For a detailed look at ACOs, please refer to the Deloitte Center for Health Solutions report, "Accountable Care Organizations: A new model for sustainable innovation."⁵⁷)

Currently, a variety of bundled payment approaches are being tested (Figure 2). In California, the Integrated Health Association (IHA) is piloting bundled payments based on "episodes of care" to stimulate efficient resource utilization while improving quality and providing shared savings for providers.⁵⁸ Under CMS' medical home demonstration, physicians are assigned beneficiaries with multiple chronic conditions and receive a per-patient care management fee in addition to FFS payments for providing comprehensive and coordinated care.⁵⁹ CMS' Acute Care Episode (ACE) demonstration explores a global bundled payment approach wherein physician and hospital services receive one payment for certain orthopedic and cardiovascular inpatient stays. In this demonstration, CMS plans to share savings with both beneficiaries and providers; beneficiaries may receive payments in an amount to offset their Part B premiums.^{60, 61} This model directly incentivizes consumers to partake in the management of their health.

Figure 2: VBP Payment Reform Initiatives^{62, 63, 64, 65}

Initiative (Sponsor)	Provider Type	Incentive	Implementation Dates
Acute Care Episodes (Medicare)	Physician hospital organizations treating patients with hip/knee replacement surgery or CABG	Bundled payment for all physician and hospital services based on competitive bids submitted by the provider sites involved in the demonstration	Began May 2009; ongoing
Medical Home Demonstration (Medicare)	Physician practices with at least 150 Medicare FFS beneficiaries	Practices share up to 80 percent of savings if demo saves Medicare more than 2 percent	Launched January 2010; ongoing
Integrated Healthcare Association (IHA)	Physicians of the IHA P4P program (40,000 physicians; 7 California health plans)	Payments to physicians based on performance on clinical/outcome measures and reporting; determined by each health plan	Established in 1994; ongoing
Health Care Incentives Improvement Institute (HCII) -Bridges to Excellence (BTE)	Primary Care Physicians	Financial incentives are tiered based on clinical process, outcome and structural measure performances to promote continual quality improvement	Began August 2008; ongoing
-Prometheus Payment	Providers and care settings	Payments withheld from providers (10 percent) and care settings (20 percent) from risk-adjusted, evidence-informed case rates (ECR) are earned back based on performance	Pilot under way
Geisinger Health System (ProvenCare)	Cardiac surgeons who perform CABG	Financial reward if actual costs are lower than bundle payment for all inpatient and 90 day post-operative services	Program went live for CABG February 2006; programs for other conditions currently under development

Finally, for beneficiaries participating in Medicare Advantage (MA), CMS will now rate the quality of MA health plans using a five-star rating system. Star ratings are a composite measure of the quality of care, access to care, provider responsiveness, and member satisfaction provided by the health plan. Plan star ratings will be publicly reported on CMS' website to aid beneficiaries in plan choice.⁶⁶ Similar to other VBP initiatives, high-performing plans (those achieving more stars) will receive financial rewards.

Implementation of VBP: potential challenges

Validity and reliability of measures

While the goals of VBP are clear, its implementation poses significant operational challenges. Measuring and monitoring quality may be overwhelming for providers due to the volume and non-standardization of measures.⁶⁷ Inconsistent and often non-comparable performance reports from various providers may make informed decision-making more challenging for consumers/purchasers.⁶⁸ Additionally, process quality measures (i.e., adherence to evidence-based medicine [EBM] guidelines) may not necessarily correlate with patient outcomes (i.e., mortality, readmission rates); therefore, collecting meaningful measures is essential.⁶⁹ Quality metrics are only as good as the data collected; hence, the reliability and validity of the quality data collected is critical.

Quality data collection and reporting may be dually challenging for small provider groups or those serving lower-income communities, as it may potentially require additional human/capital resources.⁷⁰ Implementation of certified and interoperable health information technology (HIT) and electronic health records (EHRs) can greatly facilitate these efforts, but not without additional costs.⁷¹ CMS provides funding for providers (\$2 million base payment for hospitals) meeting "meaningful use" criteria of EHRs, which includes reporting performance measures to CMS.⁷²

Return on investment: is upside significant enough to alter delivery system behavior?

For hospitals not achieving performance targets and ineligible for incentives (at least above the 26th percentile), fixed operating costs could challenge the viability of the hospital. Provider performance and cost of care are not necessarily correlated; low-performing hospitals, therefore, could be at risk.⁷³ A recent study of performance data from a large network health maintenance organization (HMO) found that P4P may have the unintended consequence of providers shifting resources to rewarded quality measures and away from unrewarded ones, thereby maximizing incentives while potentially decreasing overall quality of care. This study also concluded that it had failed to uncover a "substantial improvement or notable disruption" in quality of care following P4P initiatives.⁷⁴ Until additional VBP demonstration evaluations are conducted, the true impact of this payment reform is yet to be realized.

Another potential drawback of VBP that will require careful attention is the promotion of health disparities due to unachievable quality targets.⁷⁵ Not all providers treat the same patient types and not all providers have access to the same services. Therefore, if quality targets/benchmarks are not stratified appropriately, (i.e., teaching hospital, clinically integrated system or standalone, size, availability of services, patient demographics, etc.), certain providers may fail to achieve quality standards and continually lose financial incentives to those inherently able to meet quality targets.^{76, 77, 78, 79} CMS acknowledges this risk and is soliciting stakeholder guidance on ways to avoid or minimize this unintended consequence.^{80,81}

Finally, under CMS' VBP model, financial incentives may decrease over time for consistent high performers.⁸² While the baseline standard of care may nonetheless increase due to the establishment of VBP quality targets, decreasing rewards may lead to a plateau effect in improvement of quality of care. Rewarding consistent performance improvement, even for high performers, may be necessary to sustain quality improvement;⁸³ therefore, reward size is important. This is particularly true for those providers who are farther away from adopting a VBP model than others, where the costs of implementation may simply outweigh the financial incentives.

Strategic implications

Interest is high in both public and private health care sectors to achieve better health outcomes and value for funds invested. CMS has made significant strides in transforming the current health care payment system from one that rewards volume into one that rewards value. Health care reform can accelerate VBP as cost and quality concerns are aligned. The keys to successful, widespread implementation of a VBP model include the adoption of useful and workable quality measures; meaningful performance metrics that encourage rather than burden providers; risk adjustment, where appropriate; the avoidance of creating additional health disparities and reducing existing ones; and the provision of valued incentives that encourage participation and drive improvement.

Key takeaways for stakeholders

All stakeholders:

- Historically, an initial criterion for all CMS VBP programs has been budget neutrality. Health reform's implementation of VBP will likely continue this expectation for each health care sector. Underperformers face cuts that fund rewards/bonuses for the best performers. Stakeholders need to prepare now to determine how they will rank relative to their peers and implement action plans to mitigate future shortcomings for margin preservation in this zero-sum game.
- Data (quality, efficiency, patient satisfaction, safety, etc.) from VBP programs are expected to be public to promote transparency and informed decision-making.
- Informational needs are increasing, requiring more data collection and storage, new measures moving from structure/process measures to outcomes measures, analytical resources to mine and report outcomes, ICD-10 implementation, and health information networks for data aggregation.
- Value-based insurance benefit design offerings will likely increase, as offerings are more finely tuned to narrower patient population characteristics gained with more data and information resources.
- Providers and payers are expected to become more integrated, offering condition packages with bundled reimbursement. Unlike the failure of previous capitation programs, wherein providers assumed too much risk, payers will retain the insurance risk while providers will retain performance risk.

- All players in the health care ecosystem will be impacted by VBP. Opting out of VBP from the inception of the program won't be an option unless providers are willing to accept lower payments. The money to be made will be on the back end by demonstrating superior outcomes for care.

Hospitals and medical groups:

- VBP provisions in PPACA are mandatory and have definite time frames; providers should prepare now or face the possibility of short-term losses.
- The greatest gains will likely come from well-care and early intervention, not sick-care. The goal is to avoid hospital admissions and, in particular, readmissions.
- Stakeholders not already participating in VBP demonstrations should consider integrating quality measure collection into their daily business practices to lessen the system shock when VBP goes live.
- Patient experience is a key driver and attention should be paid to optimizing patient-experience quality measures.

Employers:

- Contracting with providers using a VBP design presents an opportunity for self-insured employers and business coalitions that contract collaboratively. VBP provides an important framework for local-level employers contracting with providers, especially if done in concert with an organized group of employers via a business coalition.
- Educating employees and retirees about VBP is essential to mitigate presumptions that higher costs are associated with better quality persist. Using hard data about costs, outcomes, safety, et al, is essential to VBP education.

Commercial health plans:

- Health care reform's VBP programs will be driven by Medicare, but commercial payers and state Medicaid programs will follow closely behind. Commercial plans should consider local-market collaboration using VBP metrics to define networks. Although VBP already is central to each plan's unique contracting strategy, the collective impact of multiple plans' use of the same methodology for scoring "value" will likely accelerate provider responsiveness and enhance enrollee understanding and support.
- Health plans should align metrics of their performance with VBP-approved measures, although not be exclusively limited to them.

State and federal government:

- Comparative effectiveness research is expected to be a pipeline to continuously inform and identify new ways to reduce waste and Wennberg systematic variation in health care delivery, and to improve patients' clinical and financial outcomes. Continued policymaker support for the creation of data warehousing efforts that combine clinical and administrative data, support transparency in data use, and facilitate interstate applications are important themes as the government implements VBP.
- Special attention should be paid to dual-eligible populations in VBP design. These patients are particularly problematic to states and pose a unique challenge in medical management and provider access. State and federal policymakers should consider VBP pilots for dual eligibles that incorporate increased bonuses for states that innovate in managing this population.
- The federal government should consider ways to educate consumers about VBP and other forthcoming data that results from health care reform. While transparency is inherent in the law, the potential exists for consumer information overload. A thoughtful, cross-agency approach to health care system education should be advanced as part of the health reform effort.

Consumers:

- Educating consumers about value in health care, and providing tools that equip them to compare costs, access, outcomes, safety, user experience specific to episodes of care, local and regional providers, and health plan performance are imperatives for a reformed system. Consumer tools must be personalized, accessible in teachable moments, web-based using a variety of platforms, and available at no cost to consumers.



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