

HEALTH REFORM WEEK

Business News and Strategies for Health Plans, Pharma, Hospitals and Providers

Hospitals Should Plan Now for Value-Based Purchasing, Which May Be Game-Changer

The health reform law's provisions regarding "value-based purchasing" (VBP), which tie Medicare reimbursement to clinical process and outcome measures, could mean a sea change for the culture of health care, some experts say. Hospitals have received "pay for reporting" for the last several years, but this will be the first time CMS is paying for outcomes. And though the VBP provisions don't go into effect until 2013, CMS will begin scoring hospitals much sooner than that — possibly as early as three months from now.

The Patient Protection and Affordable Care Act states that "the Secretary shall establish a hospital value-based purchasing program...under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards."

Bill Darling, a health care attorney with Strasburger & Price LLP who practices in Washington, D.C., and Austin, Texas, explains that "the government is trying to move away from intuition-based diagnoses and treatment into an evidence-based program.... Value-based purchasing holds hospitals accountable for getting physicians following clinical guidelines and getting successful outcomes. It converts the way providers are paid into a metric."

"We're rebuilding the entire payment system from top to bottom, basing it all on quality. This is going to be a driving force," says attorney Kathy Darling, also with Strasburger.

CMS will look at three areas in determining quality of care, says Bill Darling, who created the Value Based Purchasing Blog:

- ◆ **Physician outcome:** Did the patient's condition improve?
- ◆ **Service outcome:** Was the patient satisfied? Was there transparency in the reporting?
- ◆ **Efficiency:** What was the cost? How much was the Medicare spending per beneficiary?

Under the provisions, the clinical measures used for those incentive payments during fiscal year 2013 must cover at least the following conditions and procedures: acute myocardial infarction, heart failure, pneumonia, surgeries and health care-associated in-

fections. The precise standards are not fleshed out yet and won't be until the regulations are released, which HHS is targeting for this fall. Patient satisfaction will be measured in part using the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS). Efficiency will not be considered until fiscal 2014 and beyond.

The implementation of a VBP program has been in the works for years. In 2003, CMS introduced a public-private collaboration, known as the Hospital Quality Alliance: Improving Care through Information, to improve quality. Two years later, it created the Hospital Compare website, which makes quality-of-care information available to the public. Starting in 2007, hospitals that did not submit quality data received a 2% reduction in their payment update. According to CMS, nearly 95% of hospitals successfully participated in the "pay for reporting" initiative for 2007.

Premier Project Serves as a Model

In 2003, CMS also partnered with the Premier health care alliance to form the Hospital Quality Incentive Demonstration (HQID) pay-for-performance project — which has become the model for the VBP reform program. More than 250 hospitals with varied demographics nationwide participated in HQID, which lasted six years.

During the first three years of HQID, hospitals were measured on 32 quality process measures, such as whether cardiac patients received aspirin on arrival, and outcome measures, such as mortality rates. Those hospitals in the top decile for performance received a reward; those in the bottom decile got penalized. However, these results evidenced a "meaningless statistical difference," says Blair Childs, senior vice president at Premier. The top hospitals remained at the top, and the lower-performing hospitals made only enough progress to "get out of the penalty box."

The payment formula changed for the next three-year period to reward hospitals for either attainment of the benchmark or for improvement, whichever yielded the greater bonus. The health reform provisions incorporated this reward structure.

According to Childs, "Hospitals in HQID outperformed everyone else in the country," despite the fact that the hospitals included in the demonstration started off below the national average for performance. "It was a combination of transparency of results as well as financial incentives that made the difference," he says.

Premier worked closely with lawmakers to shape the reform legislation. The majority of the elements in the demonstration made it into the law and will be in the regulations as well, Childs states.

However, one difference between the Premier program and the law is the funding for bonus payments. Under the law, diagnosis-related group (DRG) payment withholdings will begin at 1% for fiscal year 2013 and ramp up to 2% by fiscal 2017. The bonuses, based on the process and outcome measures, will come out of this pool of DRG money. Bonuses in the demonstration came from a budgeted amount that was not based on penalties.

The other major change from the demonstration model is the inclusion of the efficiency standards. This is a "big deal," says Bill Darling. "We've always had the medical-necessity requirement for Medicare payment, but now pay will be affected by whether people are doing things in a cost-effective way...I think initially [the guidelines] seem somewhat pedestrian, but [they] will then move to ultimately a pretty sophisticated system" for calculating reimbursement.

Although efficiency was not measured during the Premier demonstration project, it was a focus, says Robert Garrett, president and CEO at Hackensack University Medical Center (HUMC) in New Jersey. "By becoming more efficient, you're actually improving quality. If length of stay is too high, you're more likely to have complications like hospital-acquired infections," he says. HUMC was the highest-paid hospital two years in a row during the program.

Hospital Admissions Could Plummet

The benchmarks used in the VBP program will evolve as hospitals improve, explains Kathy Darling. "It's a constantly moving target....At some point everyone in the universe will be handed an aspirin when they walk in the [hospital] door. That won't distinguish you from everyone else," she says.

Over the long term, VBP could be a catalyst for even more momentous changes to the system.

According to Bill Darling, VBP is a big step toward a bundled payment system, under which Medicare would administer one payment for everything occurring between the ambulance and discharge. "That's where this ultimately leads," he says.

Alice Gosfield, chairman of the board for the Health Care Incentives Improvement Institute, a nonprofit organization that works on payment reform, says that as the quality of care goes up, "hospitals will see a serious decrease in admissions." Patients with "potentially avoidable complications" and chronic conditions in particular will not require hospitalization. "The challenge for the guys in the C-suite," says Gosfield, a health care attorney with Philadelphia-based Alice G. Gosfield & Associates, "is to figure out what the business model will look like when patients are getting proper care. That may mean downsizing" or changing their focus.

Garrett agrees that admissions will decline and that hospitals will face a shifting role. "Hospitals will become larger outpatient and ambulatory care providers," he says — a trend that is already growing. Even so, patients requiring specialized services will still need to be hospitalized as care quality improves, he says, although possibly for shorter stays.

While the new provisions don't take effect until 2013, the program applies to payments for discharges that occur on or after Oct. 1, 2012. "In reality," says Childs, "they'll start measuring folks before that. It starts affecting pay in October 2012, but it will be based on performance for a period of time before then." CMS may begin collecting data as early as this October, he says.

Contact Bill Darling at bill.darling@strasburger.com, Kathy Darling at kathy.darling@strasburger.com, Childs through Amanda Forster at amanda_forster@premierinc.com or (202) 879-8004, Garrett through Mary McCarthy at marymccarthy@humed.com and Gosfield through Cary Conway at (972) 731-9242 or cary@conwaycommunication.com. ♦