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Value-based Payment: The High Cost of Confusion

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Value-based Payment: The High Cost of Confusion

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Introduction

Healthcare reform may seem overwhelming to many in the hospital world. There are a host of new regulations, incentives for new provider integration, new quality measures (and many more to come), a range of reimbursement reductions and new disincentives for healthcare-acquired conditions and preventable readmissions, among myriad other changes.

Anecdotal evidence and survey results suggest that there is widespread confusion about the timing of various reforms, about what is really in the reform law and about what to do to respond to those changes. Many health systems and integrated delivery networks are rushing to buy physician practices and form new accountable care organizations (ACOs) to gain a foothold under the new Medicare Shared Savings program. Others are girding themselves for bundled payment, under which any of an array of different providers from physicians to hospitals to post-acute providers can band together to share a single payment for an episode of care.

ACOs, medical homes, bundled payment and other new initiatives are promising experiments. ACOs will roll out next year, but only for a three-year test of the new Shared Savings Program. The other initiatives are all pilots and demonstrations. Though testing of those ideas is important, they won't fully roll out nationally for a number of years, and will only do so if those tests show they are achieving the lofty goals established for them. Meanwhile, it seems that many leaders of health systems and supply chain officials are less prepared for a more fundamental and permanent change happening quite soon: The Hospital Inpatient Value-Based Purchasing Program (HIVBP).

This new payment methodology places a portion of virtually every hospital's Medicare reimbursement at risk, beginning with 1% in fiscal year 2013 and growing incrementally to 2% in fiscal 2017. Hospitals that want to hang onto full reimbursement must either hit benchmarks for attainment on a range of quality indicators and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, or demonstrate strong improvement on those metrics.

On average, U.S. hospitals will have around \$750,000 at risk annually for their performance on a range of quality and patient satisfaction measures. Only a small number of hospitals will either keep their full reimbursement or perhaps gain some added reimbursement. Most will lose significant amounts of revenue.

More in Store

The picture, however, is even more complex than that. HIVBP is just one piece of the Centers for Medicare and Medicaid Services' (CMS) plans to shift from volume-based to value-based payment. The Patient Protection and Affordable Care Act and an earlier law, the American Recovery and Reinvestment Act, call for additional programs to be implemented that will put a much greater portion of a hospital's Medicare revenue at risk, should hospitals' performance fall short of targets. While certain details about the scope and timeline of these initiatives have yet to be worked out, their overarching frameworks are well-established. Those additional programs cover:

- Healthcare-acquired conditions (HACs): Already, hospitals are not reimbursed for certain preventable conditions acquired in the hospital. But beginning in 2015, CMS will rank hospitals on their risk-adjusted rates for certain HACs. Hospitals in the top 25% of that ranking will lose 1% of their baseline MS-DRG payments.
- Readmissions: Beginning in 2013, CMS will rank hospitals according to performance on a 30-day readmission rate for heart attack, heart failure and pneumonia. Hospitals with excess readmissions will be subject to a 1% reduction in Medicare reimbursement. In 2015, the scope of diagnoses and conditions will expand to include chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous coronary intervention and other vascular conditions. Also in 2015, the penalty for excess readmissions will increase to 3% of Medicare reimbursement.

- **Meaningful use:** As part of the American Recovery and Reinvestment Act, and further defined by the Office of the National Coordinator for Health Information Technology, beginning in 2011 and continuing until 2014, hospitals will be eligible for incentive payments in return for demonstrating meaningful use of certified electronic health record technology, such as electronic prescribing. However, beginning in 2015, hospitals that fail to meet meaningful use criteria will be penalized. That penalty starts at 1% and increases to 5% by 2018.

All told, these programs will put as much as 11% of a hospital's Medicare payments at risk.

Although many in healthcare seem to view these changes as something totally new, the concept of having Medicare revenue at risk is not new at all. Since 2005, 2% of hospitals' Medicare annual payment updates have been linked to facilities' abilities to successfully and accurately collect and submit data on a subset of the National Hospital Quality Measures and HCAHPS measures to CMS.

Not a New Concept

Value-based purchasing is neither a Democratic nor Obama invention. The process can be traced to President George W. Bush and HHS Secretary Michael Leavitt. Leavitt proposed a Four Cornerstones approach to solving healthcare's cost/quality conundrum. The cornerstones were standard quality measures, cost comparisons, interoperable electronic health records and payment incentives. In 2007, CMS proposed a value-based payment program to Congress.

As Leavitt wrote at the time, VBP is "not only going to improve efficiency, but it will also eliminate duplication and unnecessary services."

The value-based approach recognizes that healthcare spending is out of control, and yet the care being delivered doesn't come close to deserving the dollars that are being spent.

In 1970, we spent \$75 billion on healthcare, which amounted to just over 7% of gross domestic product. By 2008, those numbers had exploded to \$2.3 trillion or 16% of GDP. Spending is projected to reach 17.3% of GDP in 2009 and 19.6% by 2019. That translates into \$4.1 trillion or \$12,782 per man, woman and child in the U.S.

For all that spending, the U.S. ranks below most developed nations on life expectancy and other critical measures of health outcomes. Studies show that upward of one-third of all dollars spent on healthcare is wasted on unnecessary care, fraud and medical errors.

Details of the Program

The HIVBP program takes a version of previous quality of care and HCAHPS measures that were reported on the Hospital Compare website, but it converts rankings on those measures into points. For each of 17 quality measures and eight HCAHPS measures, hospitals can earn up to 10 points for attainment over a benchmark level or 10 points for improvement on the measures. The HCAHPS scores are rolled up to one score that represents 30% of the total HIVBP score; the Core Measures are rolled up into a single quality score equaling the remaining 70%. The total score is then used to calculate how much of the Medicare withhold a hospital can "earn back."

For many hospitals, winning back much of the withhold is going to be quite difficult. Across the U.S., HCAHPS scores are quite variable, with larger hospitals having much more difficulty in achieving high scores. With many hospitals having already topped out their Core Measures scores, it will be extremely difficult to "win." A hospital achieving at the 98th percentile may still lose points on some of the measures.

Supply Chain's role under HIVBP

Believe it or not, the supply chain will play an important role in helping hospitals win under HIVBP. For example, a lot of attention will have to be paid to the location of supplies and pharmaceuticals. As a result of the implementation of DRGs and new cost pressures, most hospitals moved to centralized supply systems, which are cost effective and efficient for pharmacy and materials, but created huge burdens on caregivers and began to undermine the patient's experience. Patients waited longer for drugs and other supplies, using call buttons to get someone to respond. That drove patient satisfaction scores downward. A few years ago, many in healthcare began to realize that decentralized meds and supplies not only contributed to the patient experience, but also to the quality and safety of care.

A second area is supporting nurses. Under value-based purchasing, nurses are the new rainmakers; they are there at the bedside with the greatest opportunity to improve the patient experience. In fact, the nurse is a proxy for all the other things that happen to a patient. So when patients are rating nurse quality, they are actually rating all of the systems in the hospital. When a supply is not there, the patient will attribute that problem to the nurse. When an IV pump has no automatic off switch for the alarm, that contributes to a dissatisfied patient.

Quality care and patient safety is every department's business in a value-driven health system. The supply chain contributes to that through programs such as RFID tracking of drugs and supplies, through standardization of products that are of the highest reliability and quality, and through ensuring the right treatment is delivered to the right patient at the right time.

A lot of what leaders must be doing now is to stop doing things that are based on the volume approach to healthcare. We may need to slow down before speeding back up. Slow down to find ways to avoid healthcare-acquired infections. Slow down to avoid wrong-site surgeries. Slow down to avoid giving a patient the wrong drug or inappropriate medical device. Slow down to come up with checklists for avoiding those problems.

We now need to focus on improving all of the processes in the hospital and sustain that improvement over time. All leaders in a hospital have to come to grips with a shift from paying for doing more to paying for doing well. The supply chain is no exception.

Questions:

1. Is your organization prepared for success under value-based purchasing?
2. How aware are you of your organization's HCAHPS scores?
3. What role should the supply chain play in improving the patient care experience?
4. What role can the supply chain play in improving scores on Core Measures?
5. Do you think that value-based purchasing will enhance, diminish or hold harmless the supply chain role in your organization?

