

KEY HEALTHCARE REFORM INITIATIVES: Hospital Value-Based Purchasing Program

HEALTHCARE REFORM
A Huron Healthcare Series

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OVERVIEW

One of the many ways the Patient Protection and Affordable Care Act (PPACA) aims to improve the quality and affordability of the care hospitals and health systems provide is through a new program called the Hospital Value-Based Purchasing (VBP) program. In short, the Hospital VBP program is the Centers for Medicare and Medicaid Services' (CMS) approach to paying more for high-quality care, and less for low-quality care. A CMS fact sheet notes that the program is "intended to transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive."

Under this program, Medicare will reward hospitals that deliver high-quality care with incentive payments. To measure quality, Medicare will use certain process-of-care measures hospitals have already been reporting through the Hospital Inpatient Quality Reporting (IQR) Program, as well as scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *See table on page 3 for the list of measures CMS has proposed to use for fiscal year 2013.*

To fund these incentive payments, Medicare will reduce the base operating diagnosis-related group (DRG) payments for hospitals' discharges in each fiscal year (FY) starting in 2013. Reductions will be 1.0% in FY 2013; 1.25% in FY 2014; 1.5% in FY 2015; 1.75% in FY 2016; and 2.0% in FY 2017 and subsequent years.

Data collection and benchmarking for the Hospital VBP program will begin in July 2011. In October 2012, CMS will begin awarding incentive payments based on a hospital's performance relative to process-of-care and HCAHPS measures. Awards will be determined through a series of calculations based on performance compared to best practice benchmarks, or relative to improvement in performance, ensuring that every hospital is incentivized to improve.

KEY CHALLENGES

For some hospitals, improving clinical performance in the areas covered by the Hospital VBP program will simply be an extension of their ongoing continuous quality improvement work. However, for others, clinical performance improvement may be more difficult to implement and sustain—particularly if improvement requires changes in patient care management structures and processes. Hospitals will also need to look ahead to what measures will be used in the program in the future, as CMS has indicated their intent to rapidly expand the program each year.

Physician and clinician alignment will also be a major challenge, since changing clinical processes and reducing care variations are difficult issues to tackle.

In addition, all of the quality-related data evaluated in the Hospital VBP program will be publicly reported—down to the diagnosis level. This could result in reputation damage for hospitals with lower scores.

KEYS TO SUCCESS

The core capabilities needed to secure the highest incentive payments possible in the Hospital VBP program are:

- Effective quality, utilization, risk and infection management programs
- Reliable performance improvement tools and measures
- Best-practice clinical guidelines and clinical pathways
- Effective admission, discharge and transfer protocols
- Ability to improve performance in reducing hospital-acquired conditions, complications, mortality, readmissions, and other key performance measures
- Solid clinician alignment in every aspect of the clinical improvement process

HURON HEALTHCARE EXECUTIVE INSIGHTS & RECOMMENDATIONS**George Whetsell**

“Most hospitals have at least some resources devoted to improving clinical performance. But in the past, healthcare executives have struggled to link clinical improvements to financial outcomes. They may have crunched the numbers and concluded that reducing their infection rates by a few points wasn’t likely to save them much money. What’s shifting now is that there will be a real cause-and-effect economic impact. If you don’t perform well, Medicare pays you less.”

“In the first year of the program, every hospital is going to lose 1% of what their payment rate would have been historically. Then they can earn back funds based on their performance on various measures. The best performers will earn back as much as 1.8%. The worst performers will gain back only 0.2%. So how you perform on these measures matters to the bottom line. And the financial incentives for improving—and the risks for not improving—will grow as the program grows.”

Dr. John T. Kelly

“Hospitals and health systems which perform well on clinical performance measures usually have clinical organizations with engaged leaders, use their clinical information systems to identify improvement opportunities, and implement patient care management processes based on best practices. Hospitals which exceed benchmarks for quality and safety will be rewarded by value-based purchasing.”

West Johnson

“Getting physician and clinician alignment must be an urgent priority if an organization is going to make substantial clinical improvements. Hospital and health system leaders need to figure out which approaches to alignment will work best at their organization. Creating a physician compact, developing financial incentives, building deeper, more substantial relationships with physicians and cultivating physician leaders—or some combination of all of these—are effective ways organizations can make alignment real.”

Ann Kirby

“CMS considering HCAHPS scores and clinical process scores as part of the value-based purchasing program will bring more attention to the importance of being sure that patient flow, care management, and patient satisfaction programs work together and are not at odds with one another. CMS is looking to improve the patient’s care experience in a holistic manner.”

“From a nursing perspective, this is a very exciting time in healthcare. Nurses will step up and play key roles as direct care providers, patient advocates, and quality improvement participants to assure their patients receive better care and the organizations where they work thrive. Efforts to provide effective and efficient care are synergistic with nursing clinical ladders and excellence programs such as the American Nurses Credentialing Center’s Magnet Recognition Program.”

BOTTOM LINE

Hospitals and health systems must effectively manage clinical performance and patient’s perceptions of care or risk their reputations and their financial stability.

While reductions in Medicare payments under the Hospital Value-Based Purchasing program may appear nominal, given the razor-thin margins on Medicare services, the payment reductions may be significant for some organizations.

If the program is effective in reducing Medicare costs and increasing quality, it will be expanded to more and more medical conditions, putting more and more dollars at risk for low-performing hospitals.

Hospitals must begin planning now, as implementation of the new Medicare programs and payment rules are being implemented quickly and will be expanding rapidly.

PROPOSED INITIAL MEASURES FOR FISCAL YEAR 2013 HOSPITAL VBP PROGRAM¹

Clinical Process of Care Measures	
Measure ID	Measure Description
Acute Myocardial Infarction	
AMI-2	Aspirin Prescribed at Discharge
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	
HF-1	Discharge Instructions
HF-2	Evaluation of LVS Function
HF-3	ACEI or ARB for LVSD
Pneumonia	
PN-2	Pneumococcal Vaccination
PN-3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
PN-7	Influenza Vaccination
Healthcare-Associated Infections	
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 6AM 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 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	
HCAHPS	Communication with Nurses
	Communication with Doctors
	Responsiveness of Hospital Staff
	Pain Management
	Communication about Medicines
	Cleanliness and Quietness of Hospital Environment
	Discharge Information
	Overall Rating of Hospital

¹ Table published in Federal Register / Vol. 76, No. 9 / Thursday, January 13, 2011 / Proposed Rules [see page 2462]
<http://www.regulations.gov/contentStreamer?objectId=0900006480bca3fa&disposition=attachment&contentType=html>

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