

Module 2: Policy and Value-Based Purchasing

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Introduction

Value-based purchasing (VBP) can foster quality improvement throughout the healthcare system. VBP principles had traction years before the PPACA and now, private and public VBP programs cover about 50 million lives. This module explores the definition of VBP and the links between VBP, quality, and the quality enterprise.

Value-Based Purchasing Defined: A Radical Departure From Fee-for-Service

The definition of VBP can be introduced by contrasting it with the traditional FFS model. FFS pays based on quantity of services. VBP pays based on outcomes, with built-in incentives and transparency throughout the system. VBP thereby holds providers accountable for the quality and cost of their services.

The implications of transitioning from FFS to VBP are significant. For example, nearly 75% of services to Medicare beneficiaries are paid via FFS, and Medicare represents about 40% of the payer mix for the average hospital. According to projections, VBP payment reform will reduce Medicare spending by approximately \$214 billion over the next 10 years.

The 6 Key Features of Value-Based Purchasing

The key features of VBP, all aligned with the quality enterprise, are discussed below.

1. Standardized measurements

Outcomes are crucial in VBP. Therefore, how measuring standards are set, and who sets the standards, matters. Typically, each purchaser devises its own standards, which may or may not match standards set by outside organizations such as NCQA. This multiplicity conflicts with goals to create a coordinated system and improve population health. The reform legislation aims to standardize measurements.

2. Data collection

Interoperable HIT is crucial to allow systemwide data sharing.

3. Publicly reported results

Kaiser Permanente reports on the performance of clinicians, including nurses and pharmacists, quarterly. Kaiser Permanente’s self-reporting, although atypical, is worth emulating, for several reasons. Measurement and reporting are essential to quality improvement, and require a team mentality involving collaboration and trust. Team members can embrace shared accountability because they will practice to the level of their preparation.

4. Reforming the payment system to reward quality, value, and ongoing improvement

VBP supports incentives for interventions known to deliver better value. Providers are paid more for reaching or exceeding quality measures or operational thresholds. For example:

- Humana, a private plan, allows physicians to share in cost savings.
- For Community Care of North Carolina’s (CCNC’s) 1.4 million managed Medicaid patients, each network receives an enhanced per-member per-month payment for coordinating care. These payments are eligible for federal matching funds, and should also qualify for an “enhanced match” under the PPACA. A 90% “enhanced match” is made available to the states under the “Health Homes for Enrollees with Chronic Conditions” provisions of the PPACA.

VBP also involves negative incentives, penalizing inappropriate or unnecessary services. For example, Medicare will no longer pay to correct HACs (hospital-acquired conditions that could reasonably have been prevented through the application of evidence-based guidelines). Negative incentives are controversial and often unwelcome, but they can force rethinking of old ideas and produce positive changes.

For example, hospitals are motivated to discharge intensive care unit patients; otherwise, length of stay increases and costs skyrocket. Many believe that a certain readmission or “bounceback” rate is inevitable. Payers commonly review discharges retrospectively and consider premature discharge a non-compensable mistake. However, the bounceback rate might not be attributable to poor judgment, but to insuf-

efficient post-discharge coordination and monitoring—problems the quality enterprise is intended to address.

At the Columbia University Medical Center in New York City, decision makers refused to accept a 1% to 2% tolerance rate for hospital-acquired infections (HAIs), and HAIs have been eliminated almost entirely. When a hospital team at Kaiser Permanente complained about the difficulty in handling HAIs, they were told that other Kaiser Permanente teams had reported no HAIs in 18 months. Ms O’Kane concluded: “Fifteen years ago, most people believed that HACs couldn’t be helped. They were flat wrong.”

5. Engaging purchasers/consumers

VBP incentives must be allocated to providers and patients. “Consumers must share responsibility for their own health status,” said Ms James. The consumer’s role involves reporting their results and experiences with the healthcare system, and otherwise contributing to the quality dialogue. Ms O’Kane noted that when NCQA discusses quality measurement, consumers are represented (via organizations such as AARP, the National Partnership for Women and Families, and others) and provide input on standards.

To engage consumers, it must also be recognized that consumers define quality differently from providers. While providers typically focus on outcomes, consumers usually assume good outcomes; instead, consumers worry about access, and want compassionate care. Therefore, a credible quality program must encompass not only clinical quality, but coordination of care and patient interaction with the system.

6. Managing expenses (providers)

Because of reductions in and downward pressure on provider payments, cost containment (including reducing waste and non-labor costs) will become increasingly vital for survival, particularly for providers who fall short of incentive performance targets.

Population Health: The Definition of Public Health Quality

Public Health Quality Forum

Quality in public health is the degree to which policies, programs, services, and research for the population increase desired health outcomes and conditions in which the population can be healthy.

US Department of Health and Human Services (HHS)

The HHS vision for public health quality is to build better systems to give all people what they need to reach their full potential for health.

The Quality Component in VBP Programs

The quality enterprise model in general, and VBP in particular, center on communities and population health on the provider (supply) side and patient (demand) side. In addition to clinical metrics, markers of population health quality include overall access to care, access to prompt appointments with providers, and systemwide coordination for both inpatient and outpatient care, so that patients can be tracked between settings.

As noted in an earlier exchange relating to diabetes care, a population perspective is vital to the quality enterprise. “If you hit the hemoglobin A1C target, that’s only a point in time,” said Dr Dobson. “VBP involves the big picture—the total outcome for the patient and the patient population.”

Various VBP programs manifest a population-focused quality component. For Kaiser Permanente’s 1 million Medicare Advantage members, prepayments are made and providers are at risk and accountable for outcomes. Performance is scored on a variety of measures and is reported publicly. In addition to clinical concerns, members are asked to rate progress in their mental and physical health. CCNC is also committed to a population/community approach for its 1.2 million patients, via the medical home model.

Other population-centric quality initiatives are under way. For example, the Comprehensive Primary Care (CPC) initiative, sponsored by the Centers for Medicare & Medicaid Services (CMS) Innovation Center and involving 41 public and private payers in 7 states, aims to improve primary care by fostering collaboration among payers. Service delivery will be tested for markers comparable to those listed above. Providers receive a monthly care management fee for FFS Medicare beneficiaries and the potential to share in savings.

Legislating VBP

Value-based principles are embedded in the PPACA and other reform legislation. Overall, this legislative lattice reflects a mandate that CMS be transformed from a passive payer into an active purchaser of higher-quality, affordable care. [Table 1](#) lists major VBP legislation.

VBP-Based Initiatives in Medicare

CMS began implementing VBP pilot programs in 2003, grouped into pay-for-performance (P4P), pay-for-reporting (P4R), and pay-for-value (P4V) programs. Examples of these programs include:

- The Physician Group Practice (PGP) Demonstration. Participants are held accountable for specified quality measures, and share Medicare savings.

Table 1. Major VBP Legislation

Legislation	Key Aspects
Medicare Modernization Act (MMA) of 2003	Congress commissioned the IOM to recommend ways to link Medicare compensation to provider performance. IOM recommended pay-for-performance programs. MMA required certain hospitals to report on 10 specified clinical performance measures.
Deficit Reduction Act (DRA) of 2005	Required HHS to launch a VBP program for certain Medicare hospitals. DRA also established a pay-for-reporting program to further motivate hospitals to report as mandated under the MMA.
Medicare Improvements for Patients and Providers Act of 2008	Required HHS to develop a VBP transition plan for providers receiving Medicare payments.
American Recovery and Reinvestment Act (ARRA) of 2009	In recognition of the crucial role that HIT/EHRs play in the VBP equation, ARRA allocated \$2 billion to accelerate their adoption.

EHR indicates electronic health record; HIT, health information technology; HHS, US Department of Health and Human Services; IOM, Institute of Medicine; VBP, value-based purchasing.

- The CPC initiative (discussed earlier).
- The Partnership for Patients, a multi-payer P4P initiative designed to reduce preventable errors, HACs, and preventable complications during transitions between care settings.

Initial reports on these projects indicate the potential for achieving significant quality improvements. For example, during all 5 years of the PGP demonstration, all participants reported improvement in quality metrics. Medicare savings were achieved in the first 3 years and shared by the groups achieving them. The Hospital P4P demonstration reported substantial quality score improvements after 3 years. Participating hospitals received \$36.5 million in performance incentives.

The indicators with respect to savings are less positive. However, Dr Weissberg noted that “We’re getting clues about what’s realistic.”

It should be noted that the cited positive results are preliminary, and it is too early to draw definitive conclusions. For instance, critics of the PGP demonstration have noted that the quality metrics overemphasized process and neglected outcomes; not all PGP participants achieved Medicare savings, and among those that did, the extent of savings

varied dramatically; also, the total savings did not offset the cost of the demonstration.

Quality Improvement Organizations and VBP

Quality Improvement Organizations (QIOs), created under Medicare, are directed by law to improve the medical care provided to beneficiaries, reduce waste, and help beneficiaries with complaints. CMS contracts with 1 QIO in each state.

QIOs now develop quality measures for VBP arrangements, and are charged with maximizing the effect of quality-related incentives such as P4P and P4R. They help providers, especially smaller ones, implement improvements, and bring providers together to learn from each other.

The results with QIOs have been mixed.

Legislative Synergy

Some question whether the reform laws work together. Ms O’Kane believes that synergy exists, but that “A local entity is needed to make the pieces fit.” This comment echoes a core quality enterprise theme: healthcare policy may be set nationally, but actual healthcare is delivered locally, and populationwide quality builds up from there.

Dr Weissberg presented the physician’s perspective on legislative synergy. Although physicians are committed to providing effective care for their patients, they have typically lacked sufficient data and tools to gauge their success, not only with an individual patient, but compared with an entire patient population. The current reform scheme enables this capability throughout the healthcare continuum.

Access to useful information, now mandated by the law, can transform an individual physician’s practice. Ms O’Kane related an anecdote involving the last primary care doctor in the Intermountain Healthcare system to adopt EMRs. EMRs allowed him to view, at a glance, the hemoglobin A1C, blood pressure, and lipid control for his population of patients. “The doctor admitted that until [he adopted] EMRs, he didn’t really know what was going on with his patients,” she said. In a quality enterprise context, this physician had become connected to systemwide population information.

This anecdote demonstrates the bottom-up scalability mentioned above, and also explains why enhanced information capability is a prerequisite to the desired reform. Physicians with access to meaningful, systemwide data on the individual patient in front of them, and on all of the patients in their care, can better understand their own practice patterns and the overall health of their patient populations, and thus plan improvements. For that reason, the legislative

■ **Table 2.** Promoting VBP: Eight Key State Strategies

State Strategy	Examples
Identify priorities and performance requirements; impose clear consequences for hitting, exceeding, or missing them.	MGI's RFP for a PBM included parameters relating to retail pharmacy access and mail order capabilities.
Measure performance.	Iowa and Oregon continuously assess performance at the point of procurement.
Identify opportunities for improvement.	CalPERS meets quarterly with contracted managed care plans. The reviews are used to target improvement in physician performance and e-prescribing.
Set specific and measurable improvement goals to enhance contractor performance and accountability.	In Massachusetts, concrete measures were negotiated with contractors to decrease inappropriate utilization of emergency services.
Collaborate with insurers and providers to improve.	In South Carolina's Employee Insurance Program (EIP), physicians have access to the state's evidence-based claims database, giving them better capability to (a) intervene to improve health outcomes for members and (b) make treatment recommendations based on best-practice guidelines. The Vermont Office of Health Access co-locates contractors with state office staff.
Re-measure: meet with contractors regularly to review performance.	In Oregon, a metrics dashboard is used to measure performance.
Apply incentives and/or disincentives to create a business case for high performance and improvement.	CalPERS-contracted TPAs have a portion of their payments put at risk based on agreed-upon performance metrics. South Carolina's EIP contracts directly with the state's 65 hospitals. The state incents hospitals to focus on quality by tying tiered reimbursement directly to measures tracked by CMS. In 2006, 6 of the 65 hospitals received incentive payments; in 2010, 18 qualified. The Minnesota Bridges to Excellence (BTE) P4P program for physicians combines the Medicaid program, state employee health plan (SEHP), and 9 private sector employers. Providers that demonstrate excellence in outcomes for certain chronic conditions (eg, diabetes) receive both recognition and financial incentives. BTE uses the same metrics used by Minnesota health plans to reward in-network physicians; this promotes uniformity and minimizes providers' data-collection burden.
Combine forces to enhance purchasing power.	Some states (eg, Washington, Kansas, and Georgia) have aggregated covered lives in SEHPs and Medicaid to create uniform purchasing criteria and increase purchasing power.

CalPERS indicates California Public Employees' Retirement System; CMS, Centers for Medicare & Medicaid Services; MGI, Massachusetts Group Insurance Company; P4P, pay for performance; PBM, pharmacy benefits manager; RFP, request for proposal; TPA, third-party administrator; VBP, value-based purchasing.

scheme emphasizes HIT: HIT is the lynchpin of legislative synergy.

Public Purchasing Programs at the State Level

VBP is being implemented in state-level public purchasing programs. State VBP strategies focus on changing contractor behavior and holding contractors accountable.

The California Public Employees' Retirement System (CalPERS) is one of the largest public purchasing entities, with 1.3 million members. The Massachusetts Group Insurance Commission (GIC) is the state's largest purchaser of health insurance. Both use their size (and thus purchasing power) to compel improvement and lower costs. Said Dr Weissberg: "CalPERS demands better outcomes and lower costs." GIC ranks physicians on quality and cost, and offers lower-cost limited network choices; high-cost providers are excluded.

The economic downturn has inspired most states to follow suit. They press insurers, health plans, and providers to

compete on quality and price. States are particularly aggressive with Medicaid programs, because typically, Medicaid populations are the poorest, the sickest, and consume the most resources. States have also experimented with technology assessment and tight formulary management.

The 8 key state-level strategies for promoting VBP are shown in [Table 2](#).

Exchanges and VBP

Fundamentally, the PPACA is intended to foster a coordinated, high-quality national healthcare system, and give all Americans access to affordable insurance coverage within that system. At the same, each state has a unique patient population with varying health needs.

The PPACA requires each state to roll out an online health insurance exchange by 2014. The idea behind exchanges is simple and sensible, especially for employees of small businesses. These individuals might not have health insurance through their employers, or if they do, may have

only 1 plan available to them. They may have no human resources department or benefits consultant to guide them. Individual employees have no purchasing power, and would benefit from being in a group. Exchanges will gather individual consumers into a central marketplace, and together, they become a reservoir of potential customers—a group. In that central place, consumers can shop among several competing health plans, and compare information on quality and cost to inform their buying decision.

The concept has merit, but the execution is worrisome. To discern which plan might be the best for them, consumers must wade through multiple screens containing details about benefits offered, pricing, and out-of-pocket spending, along with a quality matrix. “Behavioral research shows that people have limited capacity to process information,” Ms O’Kane said.

Ultimately, the exchanges may turn out to be too complicated to propel VBP as intended. Furthermore, focus group research showed that participants dreaded buying insurance through online exchanges.

It is possible that some employers will alleviate these worries by buying insurance for their employees through the exchanges. However, Ms O’Kane is skeptical: “If the exchanges work, many employers will back off entirely. It’s easier to give employees a voucher and tell them to shop the exchange.” In the end, consumers may face the exchanges on their own.

O’Kane acknowledged the difficulty in “getting the exchanges right,” but added: “There are ways to do it; the regulators are working on it. We can do this.”

Healthcare Reform Impact on Quality and Value Initiatives

As already mentioned, the PPACA, which officially endorsed VBP, will significantly alter and hereafter shape value- and quality-based strategies. Even before the PPACA, the “unofficial” healthcare reform movement inspired VBP-related experiments.

Public Sector—State

On the public side, and as indicated in Table 2, some states are linking healthcare reform goals to state purchase activities. States have also launched programs not strictly related to purchasing. For example, Minnesota has initiated multi-payer, multi-channel reform, including the formation of the Smart Buy Alliance, a coalition among state government, private employers, and labor groups formed to improve quality in the healthcare system by agreeing to uniform performance standards, cost- and

quality-reporting requirements, and technology goals. California, Wisconsin, and Massachusetts have initiated quality measurement and reporting collaborations among providers and health plans.

Private Sector—Plans and Employers

VBP-related innovation has also taken place in the private sector, notably with patient-centered medical homes and accountable care models. Commercial health plans have used several approaches, including P4P (eg, WellPoint), penalties for HACs and preventable readmissions, and bundled payments.

For employers large and small, healthcare benefits are a constant challenge. Each year, employers must weigh and balance available coverage, choices, and costs. Some have introduced tiered benefit plan designs to encourage value-based selection of providers. Larger companies have greater market clout to extract better deals from health plans. Small- and medium-sized businesses have struggled for ways to participate in VBP or influence the market. Cooperatives and business coalitions are increasingly popular solutions. As mentioned, smaller employers may also seek better deals through the state exchanges.

Unintended Consequences of VBP

The ultimate objective of VBP is to improve population health and reduce costs. However, unintended consequences could impede the quality enterprise.

VBP might actually damage rather than enhance the physician-patient relationship. Patients, who are fixated on getting better, might lose trust if their physicians are incented to do less for them. To receive incentives, providers might perform to achieve specified metrics instead of providing comprehensive care for patients and letting the outcomes data tell the story.

Another problem could surface if performance metrics are so narrowly specified that providers remain engrossed in their own domains. “We want to break down silos, not harden them,” said Dr Dobson.

Looking Ahead

The panelists identified the main challenges facing the quality enterprise, including changing the culture of healthcare and getting key stakeholders to collaborate for the benefit of all concerned; formulating a wider array of standardized measures; improving patient safety; injecting transparency into the enterprise; involving patients and consumers in healthcare; and avoiding a preoccupation with costs, which can undermine the quality agenda.

There is a lot of work left to be done; however, concrete progress has already been made.

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