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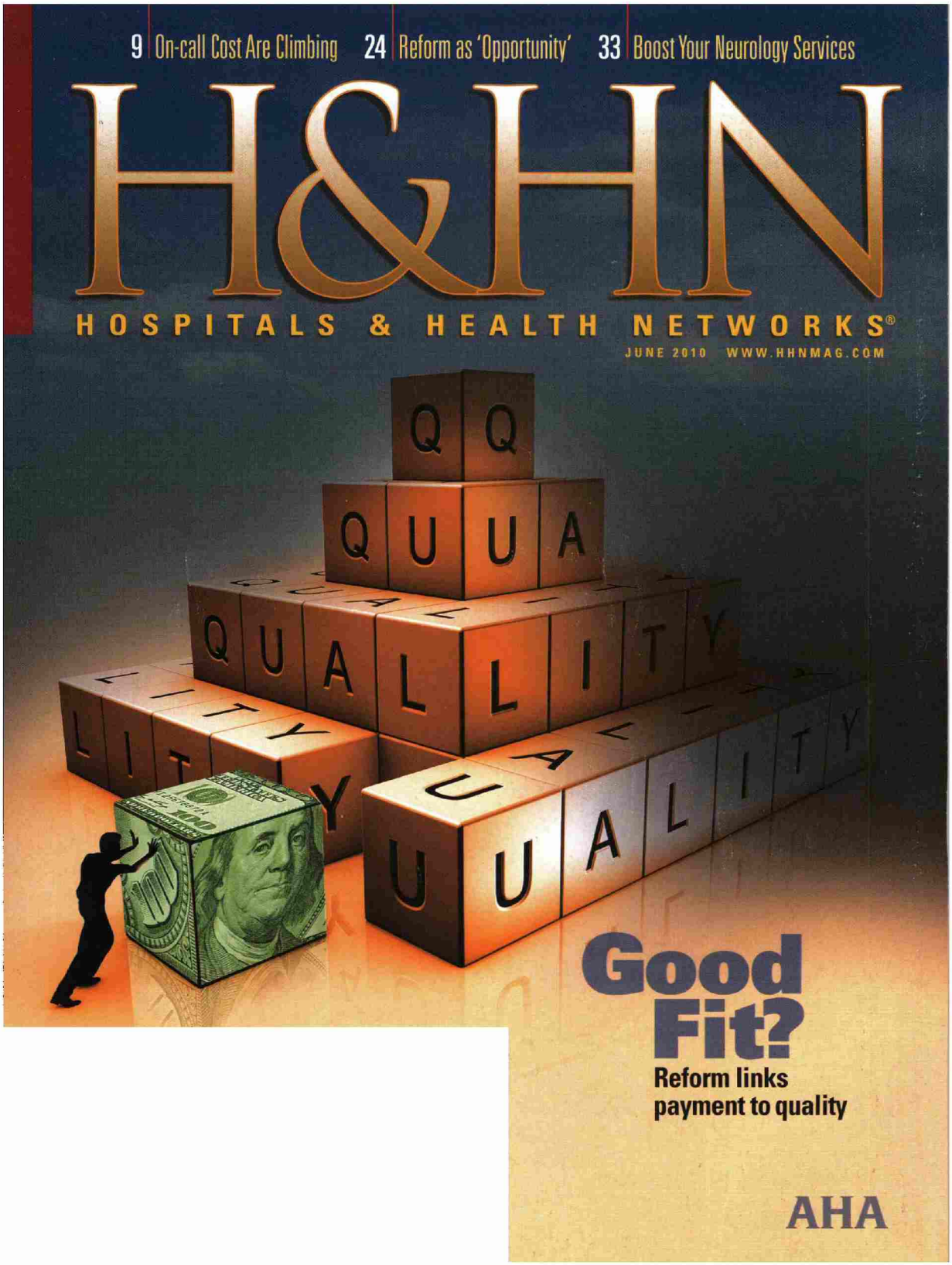

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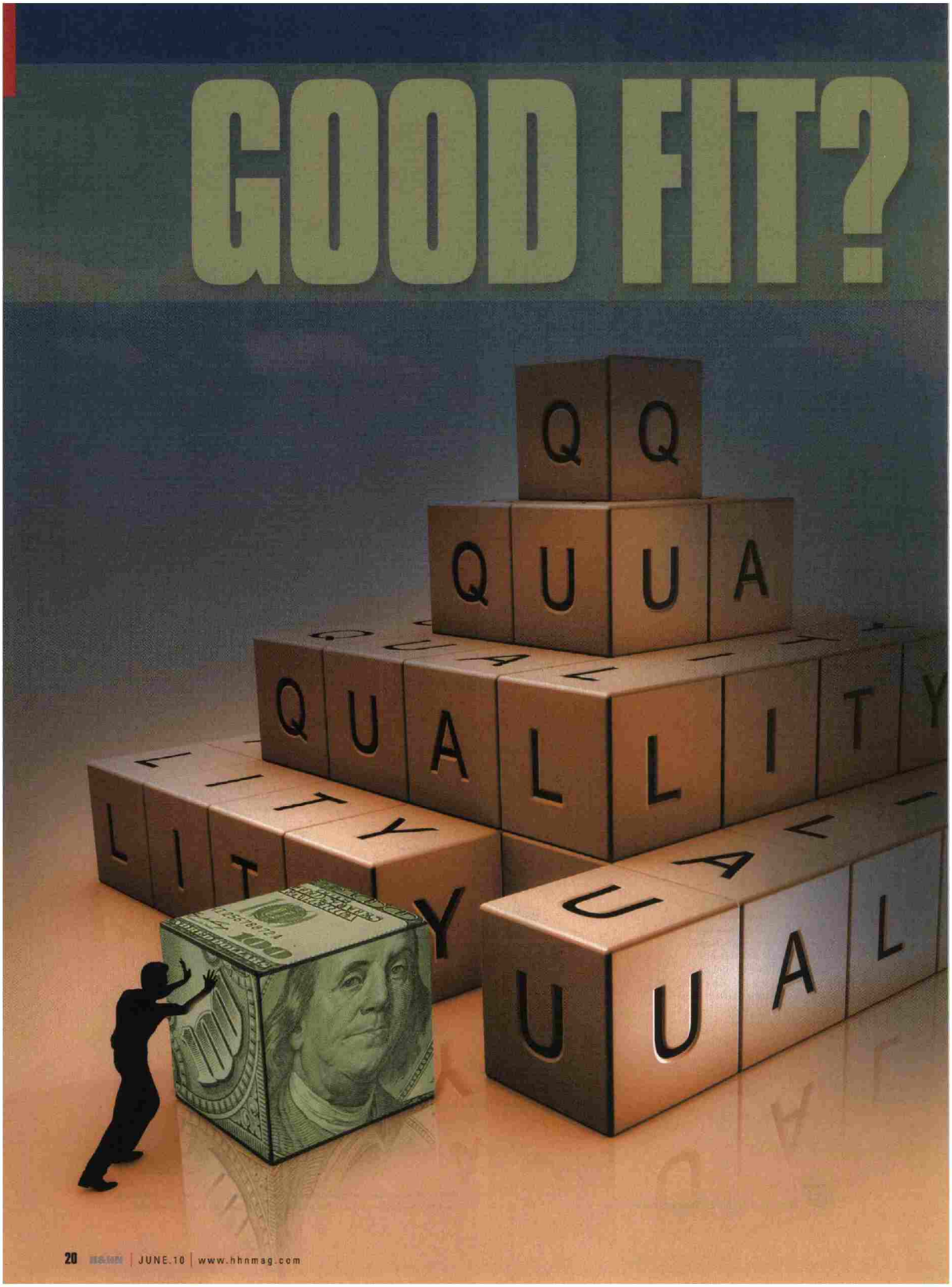

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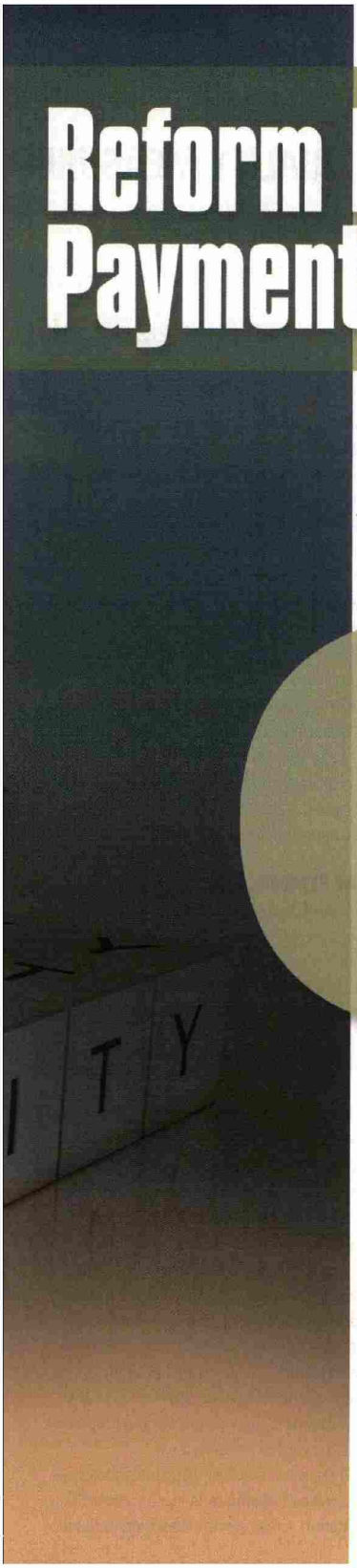
Reform Links Payment to Quality

Medicare's value-based purchasing will challenge hospitals to keep up with ever-higher, ever-changing measures—and the hard work starts immediately

BY HOWARD LARKIN



Over the course of the Centers for Medicare & Medicaid Services–Premier Hospital Quality Incentive Demonstration, which ended last year and serves as a partial template for Medicare's new pay-for-performance initiatives, the bar for earning bonuses rose very quickly.

"By the end, to be in the top two deciles you had to be near perfection on every measure," says Linda Gerbig, vice president of performance at Texas Health Resources, a 13-hospital system based in Arlington.

But achieving that performance for five categories of clinical process measures was easy compared with Premier's QUEST initiative. Now in its third year, QUEST builds on the HQID project by incorporating additional measures on clinical processes as well as patient outcomes, safety, satisfaction and financial performance. "Integrating all those measures pushed us to a whole new level of expectations," Gerbig says. And once again the performance bar is rising quickly. "In the first year, 84 percent was the top quartile for evidence-based practice; now it is 95 percent."

'A Constantly Moving Target'

QUEST is voluntary. But over the next three years, nearly every hospital will have to participate in similar Medicare P4P programs created by this year's landmark health reform legislation. These new Medicare and Medicaid programs will tie payments not only to clinical process measures, but also to clinical and patient satisfaction outcomes and to overall costs. Bonuses will be awarded to top performers, but penalties of as much as 5 percent of Medicare payments will also apply.

Adding to the challenge, new performance measures will be continually incorporated into payment formulas. "It will be a constantly moving target," says Janet Corrigan, president and CEO of the National Quality Forum, which develops consensus-based performance measures used by CMS' Hospital Compare and the Joint Commission's Quality Check programs.

Also on the docket are payment methodologies designed to push care coordination, including accountable care organizations and bundled payments for episodes of care. While these start as pilots, bundled payments could well become mandatory and developing an ACO or similar integrated delivery system may become a practical necessity to meet ever-rising quality and efficiency standards.

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What's more, performance for patients covered by nongovernment payers will soon be considered in determining Medicare payment adjustments. Pooling data also could help businesses follow Medicare into value-driven purchasing, says Helen Darling, president of the National Business Group on Health. "Having all the data from a geographic area, including private and public patients, would give insurers a reliable pool for making value-based decisions. Most insurers have their own data but not many now have the kind of pooled data we would like."

The result very well could be a shakeout of providers nationwide, says Michael E. Porter, professor of competitive strategy and management at Harvard Business School and co-author of *Redefining Health Care: Creating Value-Based Competition On Results.*

"We have been messing around with this for 30 years and this is the first coherent effort to march down the value path," Porter says. "We finally are on the right track but we need to pick up the pace."

Defining Value

Precisely how value will be defined and rewarded under the new payment approaches won't be set until regulations are written. However, the overall direction is clear and several general requirements are included in the statute. "People don't realize how quickly this will be upon us. The bonuses start in October 2012 based on what you do in FY 2011," notes Trent Haywood, M.D., chief medical officer and senior vice president of clinical improvement services for the VHA alliance. "The decisions you make in the next six months will dictate how you do in that new payment environment."

Starting October 2012, all acute care prospective payment system hospitals with sufficient volume will be included in the value-based purchasing initiative. Funded by inpatient DRG payment withholds of 1 percent in FY 2013 and rising to 2 percent in 2017 and beyond, bonuses will be based on a yet-to-be-determined formula that must include established process measures for heart attack, heart failure, pneumonia and surgical care; clinical outcome measures including hospital-acquired infections; patient perceptions from the HCAHPS survey; and efficiency measures, including Medicare spending per beneficiary. A pilot for applying VBP to critical access hospitals and low-volume hospitals also will be tested.

The good news is that bonuses may be based either on meeting an absolute performance standard or for substantially improving performance, which is similar to a 2008 CMS value-based purchasing proposal favored by the American Hospital Association, notes Nancy Foster, AHA's vice president for quality and patient safety policy. "That is the kind of thinking we believe is going to help bring the entire field along. We are hopeful that it will be the way CMS proceeds with the regulation."

However, hospitals are likely to be continuously challenged by changes in the VBP measures, says Blair Childs, senior vice president of public affairs for Premier health care alliance. "New measures will be piloted by CMS in the Hospital Compare website and moved into value-based purchasing, so keep focused on the Hospital Compare measures," he advises. But because VBP is a zero-sum game, hospitals will have to compete to maintain full payment.

Readmission Penalties

Also beginning October 2012, most hospitals will face penalties for high readmission rates. Higher-than-expected readmission for heart attack, heart failure and pneumonia will be penalized by up to 1 percent reduction in all Medicare PPS payments in FY 2103 growing to 3 percent in FY 2015 and beyond. Down the road, chronic obstructive pulmonary disease and several cardiac and vascular surgery procedures will be added for all patients with the target conditions, not just those covered by Medicare, when determining readmission rates.

Measures for both the readmission and VBP programs are to be considered by a consensus-based organization, such as NQF. However, the Health & Human Services secretary may unilaterally implement measures in some circumstances. That's important because setting readmission expectations is difficult, Foster notes. "It's important to consider whether readmissions are planned, and current measures don't take that into account," she points out.

Also, readmission rates depend on population characteristics that hospitals can't control, Childs adds. The statute calls for the bottom quartile to be penalized, which could lead to inappropriate penalties should the majority of hospitals achieve appropriate rates, he points out.

Bundled Payments, ACOs

While value-based purchasing and readmission penalties are permanent additions to Medicare payment policy, the bundled payment and accountable care organization pilot programs could also profoundly affect health care delivery. The bundled payment program starts in 2013 as a five-year pilot with HHS choosing the conditions, performance measures, global payment periods, covered services and bundling methodologies. But if after two years an independent review finds the program maintains or improves quality at the same or lower cost, HHS may extend it indefinitely and broaden its scope without additional legislative action.

Similarly, HHS will set minimum savings thresholds for bonus payments for ACOs based on a prescribed range of measures that include process, clinical outcomes and overall cost. HHS may also include partial capitation in the ACO payment methodology, and waive current laws and regulations to allow physicians and hospitals to integrate clinical operations.

These measures favor large integrated systems, a mixed blessing in Porter's view. While coordination across service sites is essential to

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for a few conditions or bonuses for all Medicare penalty programs will at distorts the market.

deliver high-value care, he believes integrated delivery networks should be organized around treating specific conditions rather than conglomerating huge multispecialty systems. "Integration should be dealing with heart failure or total knee replacement or whatever where multiple provider networks can compete."

Relying on quality measures for a few conditions or overly broad measures to govern bonuses for all Medicare payments, as the VBP and readmission penalty programs will at least initially, also distorts the market, Porter adds. "The overall infection rate is interesting but it is not actionable. A low infection rate is not a sign that a provider is actually good at stroke treatment or rheumatology. The data need to be condition-specific to guide specific purchasing decisions."

Porter points to Medicare's adult kidney transplant program as a good example of selecting providers based on demonstrated expertise in managing specific clinical outcomes. Over 20 years, one-year graft survival rates improved significantly. Darling notes that some large national employers contract with a few or even one health system for high-cost services like heart surgery based on outcomes, and transport patients across the country for the services. However, for many services, reliable data are not available, she adds.

NQF and others developing measures are well aware of this, Corrigan says. She anticipates that demonstration projects called for in the reform legislation will lead to a flowering of new measures. Some will cut across conditions, such as functional outcomes, infection rates, safety measures, palliative care and satisfaction, while others will be highly specific, such as range of motion for orthopedic procedures.

"We have an effort to prioritize conditions that lead to the majority of Medicare claims. Heart disease, COPD, diabetes, asthma—we need specific measures for these conditions," she says.

But too many measures also can be bu densome, so NQF seeks to balance the benefits of new measures with the effort required to meet them, Corrigan notes. "We have a particular emphasis on cross-cutting measures. We strive for parsimony and harmonization wherever possible because it is complicated for providers to comply."

Preparing to Excel

Because value-based purchasing will be a constantly moving target, hospitals and systems that have flexible quality improvement programs in place will be best positioned to respond, Corrigan says. "Invest in an EHR so you have the ability to electronically collect clinically rich information," she advises. "In improving outcomes, it is particularly important to have information on the patient population as well as statistical processes in place to analyze what you are doing."

But EHRs are not a silver bullet. North Shore-LIJ, which achieved the highest performance bonuses of any system in the CMS-Premier HQID pilot program, did so without a comprehensive record system in place, though the system has invested some $400 million to install a comprehensive system, says Kenneth J. Abrams, M.D., senior vice president for clinical operations and associate chief medical officer at the 13-hospital system serving Long Island, Queens and Staten Island in New York.

More important has been a management structure that sets goals at the top and cascades them down to the service level, where multidisciplinary teams focus on specific issues, such as timely antibiotic administration before surgery, Abrams says. Performance is reported back up the chain and service managers and physicians are evaluated based on their results. The system also invests heavily in training incoming managers in process improvement methods, including Six Sigma, Lean and rapid-cycle improvement. "Investing in the talent pool is essential to success," he says. The system is retraining personnel in anticipation of how comprehensive electronic records will change their roles.

Texas Health Resources, which also was a top HQID performer, has similar management structures in place, and is also spending millions to install comprehensive electronic records. "We don't shoot for what the standard is today, we anticipate where it is going," Gerbig says. "You have to stay ahead of the curve to be a top performer."

Hospitals that are used to focusing on clinical process measures also need to look at patient satisfaction measures, Haywood says. VHA has developed a gap analysis model based on past CMS proposals that factors in HCAHPS measures to estimate their impact on eligibility for bonuses. "It will be dramatically more important than people realize," he warns.

Over the past year, 210-bed Parrish Medical Center in Titusville, Fla., has used tools provided through VHA to adapt best practices in patient satisfaction and quality improvement to its specific circumstances.

"You need to look at the culture and context, whether your organization is top-down driven or collaborative and how much support you have from management and the community to determine how you can implement programs in a way that will work," says Edwin Loftin, vice president of nursing.

The AHA's Foster recommends this proactive approach rather than waiting for final regulations. "The overarching message is yes, we will continue to make performance public and we expect you to respond by striving to improve quality," she says. "While no measure of quality is perfect, we need to understand what the measures are telling us and what it means for how we deliver care right now."—*Howard Larkin is a contributing editor to* H&HN. ●

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