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INSIDE EDGE

Value-based Purchasing

EXECUTIVE SUMMARY

The Hospital Value-based Purchasing Program is a major initiative by the Centers for Medicare and Medicaid Services (CMS) to transform quality of care by realigning financial incentives. The program is based on data collected through the Hospital Inpatient Quality Reporting (IQR) Program. It begins in FY 2013 with payments for discharges occurring on or after Oct. 1, 2012.

CMS will make value-based incentive payments to acute-care hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures during a baseline period. The higher the performance or improvement during the performance period for a fiscal year, the higher the hospital's value-based incentive payment for the fiscal year.

For more detailed information visit the CMS website at http://www.cms.gov/hospital-value-based-purchasing/01_overview.asp.

To get a picture of how organizations are preparing for Value-based Purchasing, we talked to research leaders at two SI Corporate Sponsors—The Global Institute for Emerging Healthcare Practices at CSC and the Deloitte Center for Health Solutions—as well as executives at three SI member organizations—Integris Health, CHRISTUS Health and Advocate Health Care. One thing is clear, by ranking hospitals for payment, CMS and commercial payers—which are quickly adopting the VBP concept—will create a market that favors survival of the fittest.

No more 'stuff'

"Value-based Purchasing is a fancy name," says Jordan Battani, managing director of The Global Institute for Emerging Healthcare Practices at CSC, "for several major reforms aimed at converting the Medicare and Medicaid programs from predominantly fee-for-service reimbursement to reimbursement based on outcomes, or value. In a nutshell, it's an effort to stop paying for 'stuff' and start paying for results." Much of the current buzz is about how to determine just what kind of value for which the government and commercial insurers will pay under a program that reorients payment toward quality outcomes.

In the big picture value-based purchasing is the latest innovation in a series of reimbursement changes that have been launched over the last few years, notes

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Battani. "Legacy P4P initiatives, that pay bonuses to providers for achieving quality and performance goals, qualify as early steps on the journey to Value-based Purchasing." Value-based purchasing differentiates itself from those earlier efforts in two key ways: Value-based Purchasing plays on a much larger scale—the industry, rather than isolated pilots—and its incentives do not add any extra cash to existing reimbursement. It's a zero-sum game using the same pot of money, which is just going to be paid on different terms.

Jordan Battani, managing director, CSC

The trickle-down effect has also accelerated. Unlike previous Medicare changes that commercial payers adopted slowly, private insurers are "neck and neck" with Medicare in implementing the concepts of Value-based Purchasing, notes Battani. "It used to take 10 years and longer for commercial insurers to adopt Medicare strategies—think about how long it took the private sector to implement DRG reimbursement after Medicare introduced it in the 1980s. Commercial insurers now pick up those trends really quickly, and in some cases the private sector innovates before Medicare." When Medicare implemented never events in 2008, it took only about 10 days for Blue Cross Blue Shield and Aetna to incorporate similar policy.

Commercial insurers, like Medicare and Medicaid, view Value-based Purchasing as the most promising strategy to move away from fee-for-service, which is considered inherently inflationary. "What we see now is sometimes Medicare leads the commercial sector, and sometimes it's Medicare following the commercial insurers. All payers have greatly accelerated their rate of innovation. That has significant implications for the provider sector. When hospitals are faced with new reimbursement mechanisms they have a really hard time responding quickly," she says.

Patient who?

One weakness of the current Value-based Purchasing initiatives is that they focus only on actions and activities of providers – and they don't include an explicit consideration of the impact that patient behaviors have on results and outcomes. That's a critical gap given that many chronic disease conditions are greatly influenced by patient behavior and lifestyle. What's missing in Value-based Purchasing design is alignment of incentives for providers and patients. Commercial health plans sometimes address this in separate initiatives in wellness programs and value-based benefit designs that provide incentives for patients to participate in programs and engage in their own care.

"Eventually a very powerful approach would be to align the provider incentives

in value-based purchasing initiatives with patient incentives in wellness programs and benefit design," says Battani. "That way, patients and their providers would each have financial incentives to engage in activities and behaviors that mutually reinforce positive results and improved outcomes."

Trio of trials

Paul Keckley, PhD, executive director of the Washington, DC-based Deloitte Center for Health Solutions, says that Value-based Purchasing is one of an array of immediate demands on healthcare executives. "The three most significant near-term aspects of healthcare on the horizon are Value-based Purchasing, preventable readmissions and bundled payments," he says. "A, they're being implemented now or in the next 18 months. B, they require a focus on the acute episodes of care. And C, they're hitting the mark on quality metrics and outcomes."

That could explain why some savvy CEOs are putting ACOs on the backburner.

"What most hospitals miss is that ACOs and medical homes have a long-term implementation. With Value-based Purchasing, the clock's already started," he says. Hospitals need to think through how they organize their intensivists, discharge-planning process and lab and pharmacy.

It's a fundamental reordering of what is essentially a hydra-headed monster.

"Having lived in that world, it's easy to talk about team-based care, investing in IT and clinical transformation. That's redesigning on a whiteboard. Practicably, however, you're operating three hospitals: Monday through Friday days, nights and weekends," says Keckley. "Do we have the ability to capture data and organize clinical operations in these three hospitals wrapped into one facility? It's going to be even more difficult than we imagined."

Paul Keckley, PhD, executive director, Deloitte Center for Health Solutions

Deloitte.

Still, it's the right direction to go, he says, even with the C-suite focusing the IT budget and operations on ICD-10 and Meaningful Use. A Value-based Purchasing strategy is a derivative of a robust clinical and operational IT platform. But it's not plug-and-play given challenges like trying to elicit participation, for example, from a 200-doctor multispecialty practice within the health system.

Hospitals and doctors have to link up but most practices lack EMRs. "You have to build out a very robust IT platform to support clinical decision support and process measures. Executives may want to outsource discrete projects so they can put 30 sets of feet on the ground that will not hang around once the project is complete. As a CEO I need to deploy my

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fixed cost on integrating large groups and the reference laboratory. You'll have a punch list you'll have to knock out and be investing 4.5 percent to 6.0 percent of revenues in IT," says Keckley.

"This is information-driven healthcare. We're not flying with the rear-view mirror anymore."

Accountable in Oklahoma

Value-based Purchasing has served as a spark to integration for INTEGRIS Health, an Oklahoma City-based, 13-hospital health system serving patients statewide in Oklahoma.

"We've had our eye on Value-based Purchasing since CMS first announced it several years ago," says Greg Meyers, System VP for revenue integrity at INTEGRIS. "We've been doing simulations on a regular basis to see how it's affecting us. We have some winners and some losers."

Value-based Purchasing's projected direct financial impact on the health system is minimal, he says, but it has had a big impact in terms of fomenting transformation. "We've used the CMS message to reconfigure lots of initiatives within our system. It's extended our thinking beyond just the Medicare world," says Meyers.

"Value-based Purchasing discussions helped set the stage for our ICD-10 conversion and Meaningful Use adoption," he says. "We finally realized we were setting up steering committee after steering committee, so three months ago we discovered a common theme to all the initiatives. We were finding so much of the conversation is duplicative or repetitive. We took a step back to determine what the best way was for the organization to consolidate, under a single umbrella, the impact of all the regulatory requirements, the technology platform required to support these requirements and the impact on people and processes to make the required organizational change."

INTEGRIS Health

Greg Meyers, System VP, INTEGRIS Health

As a result, INTEGRIS disbanded all the committees and created a single one dubbed The Accountable Management of Healthcare Information Committee that provides cross-functional oversight to integrating the IT platform for a slew of regulatory and quality reporting initiatives including Value-based Purchasing, ICD-10, Meaningful Use and Core Measures. The committee also determines the data, process changes and human resources required for those initiatives.

Survival in the new world

"Value-based Purchasing got us really thinking as an organization about how we're going to survive in this new world," says Meyers. That thinking led to the formation of INTEGRIS Health

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Partners, an 800-physician, clinically integrated network focused on cost reduction and quality improvement that is designed to appeal to self-insured employers and commercial insurers. The new entity was born out of lengthy discussions among legal and regulatory experts at INTEGRIS in order to comply with Federal Trade Commission requirements that allow the banding together of employed and independent physicians as long as the network can demonstrate the provision of value to the community.

"In isolation Value-based Purchasing has not had a significant direct financial impact on our health system, but it has created an organizational awareness of the future," he says.

The next steps for INTEGRIS involve changing its focus from an inpatient emphasis on "putting heads in the beds" to addressing population health because future revenue will depend on it. IT infrastructure will be critical. "Information is the key to driving every strategic initiative of ours for the next 10 years," says Meyers.

"CMS lit the fire, but everybody's getting on board. Commercial insurance firms want to talk to us about high-performance network arrangements whose focus is on quality and cost efficiency. Everybody has a little different definition of value. Ours is the interplay of quality, cost and service."

Aimed for top ranking

CHRISTUS Health, a $4.1-billion Dallas-based Catholic health system with 40 hospitals in six states and Mexico, has framed its response to Value-based Purchasing strategy under a four-point strategy.

The first thrust is clinical integration[1], "which is all about positioning us at the top of the ranking," says George Conklin, senior VP and CIO at CHRISTUS. Ultimately, he says, Value-based Purchasing will lead to a list of organizations that provide care ranked from #1 to #n. "N will be the last to feed at the carcass" of reimbursement, he says.

CHRISTUS is already a high-quality organization, ranked in the Top 100 Hospitals in several of its markets by Thomson Reuters. The goal is to become an integrated network of health and wellness services that provides care to people living in the various locations within CHRISTUS far-flung markets. Depending on the location, CHRISTUS controls anywhere from 2 percent to 70 percent of the market, a factor that will shape its strategy in those spots.

[1] Clinical integration is defined for CHRISTUS Health as the geographically appropriate array of services that provide a full span of health and wellness services to customers. These would include traditional acute care and ambulatory services as well as other services that help to keep users of them well and healthy, rather than deal solely with times of illness. So, they might include, in addition to hospitals, clinics, and physicians' offices, exercise facilities, integrative health services, free-standing EDs, ambulatory service centers, pharmacies, home health and hospice services, and community health worker networks.

continued

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"We'll either drive what the strategy is or we'll partner with someone else … From an IT perspective, it's essential we develop tools to become completely integrated with our partners."

"We'll either drive what the strategy is or we'll partner with someone else. Here in Houston we have only two hospitals, so we're not going to be a major driver in clinical integration. We'll have to partner with physician practices and health systems. In all of our markets, rather than one of the larger health systems building a hospital where we already have one, we seek partnerships," says Conklin.

Market to market

"From an IT perspective, it's essential we develop tools to become completely integrated with our partners," he says. CHRISTUS has contracted with Medicity to connect all of the organization's hospitals with its clinics and many home health agencies. In some markets, CHRISTUS partners will provide that capability; if CHRISTUS is dominant in a particular market, then it will have its partners plug into its HIE to become a service provider. In other markets, CHRISTUS will link its HIE up with others to extend collaborative opportunities.

The feet on the ground in developing these strategies belong to the health system's regional business directors, who are C-caliber executives with the business acumen and leadership skills to develop new business relationships. Often Conklin joins in these discussions as well.

A second strategic thrust for the health system is to continue to develop TechSource, which CHRISTUS created as for-profit firm to roll out EMRs to physician offices and help Critical Access Hospitals to select and implement clinical HIS.

CHRISTUS Health

George Conklin, VP/ CIO, CHRISTUS Health

Third, the health system is developing its EMR-implementation capability for hospitals larger than Critical Access Hospitals as a way to standardize the organization's IT platform. "It's a lot easier than implementing EMRs for doctors," says Conklin, adding that HIEs are not yet ready to function as integrators because they still face complicated data challenges such as how to normalize data among disparate entities.

Managing Dr. Y

Implementing EMRs under HITECH demands integration on multiple levels. "We're required to include CPOE, which forces us to develop order sets. Order sets are essentially workflows," he says. "A patient presents with a broken leg and here are the steps you take to treat her. The power of a clinically integrated system is that you can do workflow management across the integrated delivery system—hospitals, home health agen-

cies, doctors' offices and exercise facilities. You can have somebody oversee care to ensure, among other things, that she doesn't have a relapse." Again, HIE technology does not yet have the capability to support such care management.

Business Intelligence is the fourth area of focus for CHRISTUS in preparing for the Value-based-Purchasing world. "We need to be able to analyze data across the delivery network. Is Dr. X a little better than Dr. Y in providing care for diabetics? Why? We may need to help Dr. Y manage better," says Conklin. BI also delivers answers at the best-practices level; in other words, identifying the best providers overall, asking why they are the best and then implementing those best practices across the network.

"You can look at process across the delivery network and identify bottlenecks, inefficiencies and dissatisfactions of clinicians. You can also integrate that with existing databases like patient satisfaction and bring in health information to online medical staff. So, we're aiming BI at the clinical, operational and financial level," he says.

Conklin stopped short of saying the organization was preparing for ACOs. "We've elected not to do an ACO, but instead to build the best clinically integrated network. I think it's an appropriate posture for organizations to take. It gets you out of having to develop insurance-management capabilities, which are highly complicated. Instead we'll carve out our place in integrated service delivery."

Little steps, big steps

Oakbrook, Ill.-based Advocate Health Care, a 12-hospital integrated delivery system serving metro Chicago and central-Illinois markets, is confident that its comprehensive strategy for the future will more than accommodate Value-based Purchasing.

"We're looking at Value-based Purchasing as foundational steps, little steps," says Lee Sacks, MD, Advocate's CMO. "We're looking more at the big picture of population health and ACOs. We'll be successful in the short run and the long run if we do this for the communities we serve and not just carrots and sticks for CMS." Value-based Purchasing creates penalties and incentives to get organizations started managing population and not volume, he says, which is what Advocate is doing with its AdvocateCare, a framework for implementing accountable care and reform. [For a detailed description of Advocate's strategy, see "The Movement to Accountable Care," Inside Edge, July 2011, click on Publications at www.scottsdaleinstitute.org]

Advocate is continuing to refine this strategy and is now in year two of its three-year shared savings arrangement with Blue Cross Blue Shield of Illinois. "Both Advocate and Blue Cross are pleased with where it's going," says

"We'll be successful in the short run and the long run if we do this for the communities we serve and not just carrots and sticks for CMS."

Sacks. "We've added an option for our employees in 2012 for an Advocate-centered network in addition to the benefits historically offered in our HMO and PPO plans. We saw an increase in HMO and Advocate-centered EPO (exclusive provider organization) plans indicating our employees are interested in healthcare efficiency," he says.

The 2012 HMO, which is only available with Advocate providers, builds on the accountable PPO model, and is 20-percent less expensive in terms of out-of-pocket contribution than other coverage. Advocate Physician Partners has also applied to participate in the Medicare shared savings program (MSSP) for July 1.

Advocate Physician Partners (APP)—nearly 4,000 physicians on Advocate's medical staff, including about 3,000 independent practitioners—is taking the lead on converting from a traditional PPO to one that tracks patients even if they venture outside the network of Advocate sites or physicians. APP doctors are measured on 150 quality measures, including ones associated with diabetes and other chronic diseases. Based on how well they perform physicians can earn annual incentive payments that average $20,000.

Embedded care managers

"In the long run, improving quality is going to improve cost efficiency. We're working hard to improve care in chronic disease. Also, were improving generic prescribing and ensuring there's good access to care so those patients don't use the ED unnecessarily."

"We've deliberately tried not to use the term ACO because it tends to politicize healthcare. That's why we created AdvocateCare," says Sacks, adding that incentives are less important in driving quality and efficiency in care than transparency of outcomes.

Advocate Health Care
Inspiring medicine. Changing lives.

Lee Sacks, MD, CMO, Advocate

Several Advocate practices have received NCQA certification for medical homes, and while these are limited in scope to date, it has been building the infrastructure for medical home capability across the system during the past nine years with its disease registries, helping physicians to migrate to an EMR and most recently hiring 62 care managers to assist primary care physician practices affiliated with Advocate Physician Partners.

"We've deliberately tried not to use the term ACO because it tends to politicize healthcare. That's why we created AdvocateCare," says Sacks, adding that incentives are less important in driving quality and efficiency in care than transparency of outcomes. Supporting that argument is Advocate's own data: The organization has reduced inpatient days per 1,000 patients through three

quarters of 2011 by 12.6 percent and the admission rate has dropped 11.3 percent. "We saved more than we invested in infrastructure. Our goal was to outperform the Chicago metro market by 5 percent through fourth quarter. Through the third quarter, we've done that by 4.7 percent on a risk adjusted basis."

Conclusion

Value-based Purchasing is all about bringing healthy competition into a healthcare marketplace still in the early stages of emerging from the fee-for-service world. Value is the byword. The next five to 10 years will tell the story of how well we translate that word into the delivery of care.

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