Value-Based Purchasing

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From the Editor

Uncle Sam's Debut on the Value-Based Purchasing Stage

In the fall of 2006, Secretary Michael Leavitt of the US Department of Health and Human Services announced with great fanfare that Uncle Sam was going to become a value-based purchaser of health benefits. An article in this issue of VBP highlights how the Centers for Medicare and Medicaid Services (CMS) has begun to implement this vision in the Medicare program, starting with an emphasis on hospital inpatient services, but branching out to affect all health care services, including physician services. Now that the "600 pound gorilla" has entered the game, many employers, and indeed some Benefits College alumni, may be wondering what this means for your own benefits purchasing strategy.

In answering that question, I'm reminded of how I first ended up partnering with Jerry Burgess and Andy Webber in the development of the College for Advanced Management of Health Benefits. Our Jefferson Department of Health Policy was engaged in research, supported by the Commonwealth Fund, examining whether the "value based purchasing movement had legs," i.e. did employers really care about quality? Our initial findings, published in a Fund report, included the important assessment that employers were starting to care about quality and value, and that they played a pivotal role in shaping policy. Government might have the economic and political power to influence the market, but it would not exercise that power in the absence of **proven** interventions. The *employer-led* value-based purchasing movement was, and remains, an essential driver in developing, testing, and disseminating quality and value-improving interventions that government can then adapt and implement on a national scale.

As CMS moves forward with its VBP initiatives, the employer and coalition imperative to work at the local level remains strong. Work is still needed to answer a myriad of important questions not readily approachable by the "big G", for example:

- How can quality and value data be used to drive appropriate care-seeking by consumers?

- How can the principles of "value-based benefit design" move beyond modifying drug co-payments to a broader range of value-linked benefit offerings?

- To what extent is the current wellness fad going to translate into true health improvement and cost-savings?

- How can employers work in partnership with providers and other community members to best promote value?

The list of important questions is clearly much broader and deeper. Government plays an important role in dissemination, but employers remain the central agents in figuring out what works (and what doesn't) – and sharing those experiences through publication, presentation at conferences, and networking with colleagues and coalitions. I hope that you will read this issue of Value Based Purchasing, and then get back to the important work at hand.

Neil Goldfarb, Editor
Value-Based Purchasing

The Centers for Medicare and Medicaid Services' Approach to Value-Based Purchasing

Bettina Berman, RN

Although evidence suggests that both the quality and the affordability of health care can be improved[1], it is likely that such improvements will come at great cost. Healthcare expenditures in the United States (U.S.) are expected to rise precipitously - from $1.5 trillion in 2005 to over $4 trillion in 2016. [2] Medicare, the nation's single largest health care purchaser, spent an estimated $425 billion on health services in 2007. With the projected growth in Medicare beneficiaries, the amount may surpass $800 billion by 2017, placing the government under significant pressure to control health care costs. [3]

This article is intended as a brief summary of the Centers for Medicare and Medicaid Services' (CMS) experience and its prospective strategies for health care quality improvement, including relevant legislation and potential future trends for value-based programs under CMS.

Initially, the Medicare payment system was based on provider claims for "customary, reasonable, and necessary costs." In the 1980's, Medicare introduced a prospective payment system for hospitals based on Diagnosis-Related Groups (DRG), but maintained a fee-for-service payment for ambulatory services. This payment system rewards providers for volume of services rather than the quality of those services, and encourages high resource consumption rather than efficient health care delivery. An increasing body of evidence [2] has revealed wide variations in quality and costs for the health care services provided to Medicare beneficiaries.

Armed with this knowledge, CMS developed a "Roadmap for Quality," aimed at "transforming Medicare from a passive payer to an active purchaser of high quality efficient care."[4] In an effort to take a leadership role in transforming the health care system by supporting the Institute of Medicine's (IOM) 6 aims for health care (ie, Safe, Effective, Patient-centered, Timely, Efficient, and Equitable), CMS adopted the following strategies for achieving high quality, patient centered care:

1. Work through partnerships
2. Publish quality measurement and information
3. Pay in a way that expresses a commitment to quality and rewards rather than inadvertently punishing providers and practitioners for doing the right thing
4. Promote health information technology
5. Become an active partner in creating and using information about the effectiveness of healthcare technologies

The Deficit Reduction Act of 2005 (DRA) required a quality adjustment in Medicare Diagnosis Related Group (DRG) payment for certain hospital-acquired conditions (HAC), including serious preventable events, pressure ulcers, falls, and vascular catheter-associated infections. The legislation also authorized the development of a plan for a hospital value-based program to commence in FY 2009. CMS has received support for the value-based plan from multiple stakeholders, including private insurers, the National Quality Forum (NQF), and the Medicare Payment Advisory Commission (MedPAC).

In its report, "Rewarding Provider Performance"[5], the IOM recommended that "the Secretary of the Department of Health and Human Services (DHHS) should implement pay for performance in Medicare using a phased approach as a stimulus to foster comprehensive and system wide improvements in the quality of health care." The report recommended transparency and incentive measures, stating that such measures will likely improve health care quality, but not necessarily reduce costs.

The final plan for a hospital payment system based on value was presented to the Congress in November of 2007. [6] The plan proposes a value-based program which will eventually phase out Medicare's current Reporting of Hospital Quality Data for Annual Payment Update Program (RHQDAPU). Under the new program, up to 5 percent of hospital payments would be made on the basis of a total performance score derived from measures that evaluate both clinical care and patient satisfaction.

In December of 2006, President Bush signed the Tax Relief and Health Care Act (TRHCA), paving the way for the Physician Quality Reporting Initiative (PQRI), a voluntary pay-for-reporting system aimed at individual physician and non-physician providers of Medicare services. The 2007 PQRI program, consisting of 74 measures, went into effect on July 1, 2007. For 2008, the PQRI incorporates 119 measures of clinical care, resource utilization, and structural measures (eg, electronic health records). Quality codes (CPT-II codes) are linked to the diagnostic codes (CPT-I and/or ICD-9) and submitted through the claims system. In order to qualify for a bonus of up to 1.5% of the total allowed charges for Medicare services, providers must reach a reporting compliance of 80%. Bonus payments and feedback reports from CMS, including reporting and performance rates, are expected by mid-2008.

According to CMS, the future of Medicare reimbursement for all payment systems is value-based purchasing .[7] Future development of value-based purchasing programs for hospitals includes an emphasis on development of efficiency measures. For physicians, CMS is currently exploring the feasibility of providing resource utilization reports for individual providers. Another area being investigated by CMS is an "episode of care" payment system that offers an incentive to physicians who provide both well-coordinated and cost-effective care[8] for individual Medicare beneficiaries.

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The Emerging Role of Electronic Medical Records- What Do They Mean to Quality and Value?

Richard Jacoby, MD

President Bush identified electronic medical records (EMRs), also known as electronic health records (EHRs), as one of the 4 cornerstones in his value driven health care initiative.[1] EMRs represent a "disruptive technology" insofar as they change the way we capture, store, retrieve, share, and use health information. Because they have the ability to transform and enhance virtually all communications, transactions, and analyses involving healthcare information, implementation of EMRs will have a profound effect on patients, providers, and payers. The transformation likely will parallel the one which occurred as information technology enhanced knowledge and productivity in the non-healthcare segments of the U.S. economy. As such, the ***potential*** of EMRs to have a significant and positive impact on quality and value in healthcare is great.

That being said, it is well known that the information generated by a system is only as good as the data entered into it (ie, "garbage in-garbage out"). Whether captured in electronic format or on paper, much of the information contained in medical records that relates to quality and value is entered by physicians. For a physician to enter "appropriate" information, he or she must be aware of the type of information being sought. After all, it is the knowledge base and thought processes of physicians that interact to result in the decisions and behaviors that are

documented in a medical record. If physicians lack the knowledge or education in quality metrics, the concept of value in healthcare, and the mechanics of EMR use, they are unlikely to capture the required data.

In what now is a classic paper on the quality of healthcare delivered to patients in the United States, researchers at the Rand Corporation found that recommended care that adhered to widely agreed upon evidence-based guidelines was delivered just 54.9% of the time.[2] Logically, if nothing were to change other than records being kept electronically instead of on paper, and such a study of quality were repeated, there is no reason to assume that quality performance would improve. A major study recently published in the Archives of Internal Medicine supported this premise. The study comparing quality measures pre and post EMR implementation showed no difference in 14 measures, improvement in 2 measures, and worse performance on 1 measure.[3] It is with caution then that we proceed further with this discussion of the role of EMRs and what they mean to quality and value.

What is an EMR?

Currently, there is no standard definition. In simple and practical terms however, whether used in the hospital (inpatient) or ambulatory (outpatient) setting, an EMR is a medical record that has been captured in a digital format. It may include data relating to patient demographics, medical history, physical examination and progress reports of health and illnesses, medication and allergy lists, immunization status, laboratory test results, radiology images, clinical photographs, a record of appointments and other reminders, billing records, advanced directives, living wills, and health powers of attorney.

Some important "value added" features of EMRs (i.e., unavailable in paper based records) include:

- Computerized provider order entry systems (CPOE), which include computerized orders for prescriptions ("e-prescribing"),
- Computerized reporting of test results,
- Clinical decision support systems, which may facilitate medical decision-making and provide evidence-based recommendations for specific medical conditions, and
- Computer generated prompts and reminders.

In my opinion, these additional features hold the key to unlocking the capabilities of EMRs to improve quality and value in the American healthcare system through their ability to help change and augment physician decision making.

What will it take for EMRs to impact quality and value on a national scale?

First, EMRs must become more widely utilized. In the most comprehensive study to date that reliably measures the state of EMR use by doctors and hospitals, researchers from Massachusetts General Hospital (MGH) and George Washington University (GWU) estimate that 1 in 4 doctors (24.9 percent) use EMRs to improve how they deliver care to patients. However, less than 1 in 10 are using what experts define as a "fully operational" system that collects patient information, displays test results, allows providers to enter medical orders and prescriptions, and helps doctors make treatment decisions.[4] The same study found that "hospital adoption trends are

unknown. Assertions to the contrary, there are not enough high-quality, reliable surveys of hospital use of EHRs. The research team reliably estimates, however, that about 5 percent of America's 6,000 hospitals have adopted computerized physician order entry (CPOE) systems, a component of EHRs, to help reduce medical errors and ease care delivery."[5]

I don't think EMRs will impact quality and value on a national scale until a critical mass of physicians is using "fully operational" systems. In Donabedian parlance, once the "structure" is in place, physicians can and need to be educated on the "processes" of quality and value which can result in the desired "outcomes" of enhanced quality and value. To achieve these outcomes, everyone involved with EMR implementation must appreciate that "implementation of health information technology (health IT) is one-third technology and two-thirds organizational culture and work process." [6] Physicians and the whole care team must embrace this process if the potential of EMRs to enhance quality and value in healthcare is to be realized.

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Challenges and Benefits in Using Productivity Data from Clinical Trials for VBP Decisions

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Making value based purchasing decisions in healthcare requires balancing data from several sources. Information on *effectiveness* of interventions often comes from clinical trials, with less reliance on observational studies. Historically, the opposite has been true of information on the *cost* of interventions. More recently, providers of healthcare interventions such as drugs, devices, and disease management programs have begun to understand and appreciate the importance of costs in healthcare decision making. Because of this, the clinical trials used to demonstrate effectiveness have begun to gather data on costs. This article describes some benefits and detriments of collecting cost data as a component of clinical trials, focusing specifically on the data related to productivity.

Studies evaluating the cost of an intervention can look at a variety of different types of costs depending on the perspective of the study. For

an organization whose sole function is to pay for healthcare (e.g., Pharmacy Benefits Managers), the direct costs (e.g., the price of a pharmaceutical) are the only ones with importance. For employers, it is essential to consider the indirect costs and, in particular, productivity.

Productivity can be measured in a variety of ways, but it is usually reported as an amount of *productivity lost* due to a certain disease, or the amount of *productivity loss avoided* by using a specific type of intervention. Productivity loss due to medical conditions can present itself in 2 ways. The first is *absenteeism*, often measured by means of reviewing employee records of sick days or disability leave.

The second type of productivity loss - *presenteeism* - is more difficult to measure. Presenteeism is defined as an employee being present at the work place but unable to perform at his or her usual level of productivity. This type of productivity loss is often measured by surveying employees with certain conditions. The employees are asked to report the percent of time they have lost from work as a result of their condition.

The value of lost productivity can be calculated through either the friction cost approach, or the human capital approach. The *human capital approach* yields estimates of wages lost for the time that an employee was not working. The *friction cost approach* adds to that the cost of recruiting and training additional labor to replace that which was lost. Depending on the condition and the characteristics of the work environment, either of these approaches may be appropriate.

Using clinical trials to measure changes in productivity due to a medical intervention has a number of benefits. These trials are viewed as the gold standard for understanding the impact of medical interventions on health because they control for a lot of potentially confounding issues. In these trials, patients are carefully controlled on one or more specific interventions, and the outcomes are measured prospectively. This allows researchers to arrive at strong conclusions about the causes and effects observed in the trial.

There are also some limitations when using clinical trials to measures productivity changes due to medical interventions. First, one must recognize that health is only one of many factors that contribute to work productivity. Changes observed during a clinical trial may not be due entirely to the intervention being tested. In addition, some individuals choose their jobs, at least in part, in order to mitigate the limitations of that condition. For example, a retail worker with back pain may choose to look for a job at a pharmacy rather than a home improvement store in order to lessen the likelihood of heavy lifting as a job requirement. This type of decision lessens the perceived impact of a medical intervention on productivity from a clinical trial point of view.

Interpreting studies that evaluate the impact of medical interventions on productivity can be difficult, but it is an essential step in understanding the effect of purchasing decisions on employees. For instance, it is important to understand how the conditions in which the study was conducted differ from those at the company purchasing the medical intervention. The type of work being done as well as the demographic characteristics of the workers may influence the estimation of wages for those workers.

Although it has been demonstrated that productivity loss is one of the largest disease-associated costs for employers, we are still in the early stages of measuring productivity gains due to specific interventions. As this

important information becomes more available, employers should recognize its value in making purchasing decisions. It is equally important that the consumers of this information understand the benefits and detriments of these study designs.

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From the Alumni Network

Missy Jarrott, Director of Human Resources for Chatham Steel Corporation writes:

"Do you know of any employers who offer wellness programs that hold the employee ***and the spouse*** *accountable for reaching a certain level of optimum health by means of lower premiums, specific plan designs, etc.? We currently hold our employees accountable; however, we hope to reach spouses in 2009. Any suggestions?"*

Feel free to write to Missy directly at Missy_Jarrott@chathamsteel.com. We also would be happy to post your responses in the next issue of VBP, so please copy neil.goldfarb@jefferson.edu.

Benefits College Program Schedule for 2008

The College for Advanced Management of Health Benefits will be hosting 3 course sessions in 2008. By the time you read this, the first session, in Nashville, Tennessee, hosted by the HealthCare21 Business Coalition, will have just been held. The two additional sessions for the year are:

- ***June 2-5, 2008, in Orlando, Florida***, hosted by the Florida Health Care Coalition
- ***September 15-18, 2008 in Arlington, Virginia*** (just outside of Washington DC), hosted by the Virginia Business Coalition on Health and the Mid-Atlantic Business Group on Health.

As always, the programs are open to all interested direct purchasers of health benefits, and those who act as agents on their behalf (e.g. brokers and benefit consultants). For more information, visit http://www.hc21.org/CAMHB/college_index.htm, or contact neil.goldfarb@jefferson.edu.