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Observations About Value-Based Purchasing

On April 29, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the final rule that would establish a value-based purchasing (VBP) program for acute care hospitals paid under the Medicare inpatient prospective payment system. It was to be implemented beginning in FY13 and would provide incentive payments to hospitals based on their achievement or improvement on a set of quality measures.

In publicizing the release of the rule, CMS issued a press release (or "Fact Sheet") that included the following statement, which would become its mantra for VBP: "[F]or the first time, hospitals across the country would be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide."

It's difficult to understand exactly what is meant by the statement. Hospitals have not been paid based on the quantity of services provided to a patient since the introduction of DRGs, and VBP should not affect the numbers of patients seeking care. Perhaps it just means that VBP will financially penalize hospitals if their services fall short of certain measures of care quality.

It's also troublesome to read the bleak picture that CMS painted in the press release announcing VBP. CMS stated that, in 2009 alone, one in seven Medicare patients experienced adverse events in the hospital, one in three were readmitted within a month, and that 98,000 Americans die from hospital errors each year. Did CMS really need to characterize the American health system this way?

The problem is that these statistics are controversial, misleading, and even inaccurate. For example, reputable studies have concluded that fewer than half of adverse events may be preventable and, in the study from which the 98,000 deaths were extrapolated, the death rate in another patient group with medical errors was similar to the death rate in a group without medical errors.

The readmission rate quoted in 2011 is particularly important because readmission rates are a quality measure used in VBP. The 30-day all-condition Medicare readmission rate was actually 19.0%, versus the 33.3% quoted, and it declined to less than 18.5% in 2013 when the measure began to be reported for VBP. It subsequently declined to slightly less than 18.0% in 2014 and has remained at that level through 2016. In other words, it was overstated and declined to current levels before the program began.

High readmission rates can mean that some patients are being discharged prematurely and must be subsequently readmitted for care. It is appropriate to measure readmission rates and publicly report them, but is it necessary to implement financial penalties and discredit hospital care in America? Ironically, hospitals have been pressured to discharge as soon as

possible through prospective payment and Medicare's utilization management efforts, the same group that brought VBP.

Because the typical hospital receives more than 40% of its patient revenue from Medicare, CMS has considerable leverage to dictate payment policies. As a result, most hospitals operate with negative margins for their major payer, averaging more than a negative 5% margin.

Although VBP has the potential to foster quality improvement, its current design acts to decrease payment for hospital services. Financial incentives actually involve a redistribution of monies withheld from hospital payments and financial penalties levied on poorer performers.

The statistical methods deployed by VBP also may be inappropriate. Rather than defining a standard of performance for each quality measurement, hospitals are ranked and penalties are assessed against hospitals with lower scores. This approach assumes that hospitals with below- average scores deliver low-quality care. No matter how well the industry does overall, about half of all hospitals will always be deemed to be "below average," which could be interpreted as prone to delivering "substandard" (i.e., lower than average-quality) care. This type of thinking may be applicable in industrial quality control, but it may not apply in health care where there is clinical variability among individual patients and among provider case mixes.

It might be more effective to see a program from CMS that nurtures quality improvement through educational support and public reporting rather than through financial punishment and rankings that can have a harmful effect on public perception. CMS has the resources to help develop meaningful quality measurements, recommended standards of care, and reporting mechanisms to drive quality improvement.

Most hospitals are committed to provide the best care possible and would be apt to welcome such support. Public reporting is a strong incentive because it exposes poor performance and provides positive recognition for exceptional performance.

The reality also is that modest financial incentives and penalties are probably not sufficient to drive meaningful improvement, and a complex program like VBP could waste valuable resources. Thus far, it is not clear that the VBP program has delivered meaningful quality improvements.

Everyone wants to see high levels of quality in American health care, but the VBP program as it now exists has considerable opportunity for improvement. ■

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