Chapter Seven
Value-based Purchasing

Value-based purchasing (VBP) is a pay-for-performance program that affects a significant—and growing—percentage of Medicare reimbursement for medical providers. It ties reimbursement to how well a provider meets a specific set of quality and cost standards. In directly linking the quality of a provider’s performance to the amount of reimbursement the provider receives, VBP represents a significant shift in Medicare reimbursement: from volume to value. At the time VBP was first introduced, the Centers for Medicare & Medicaid Services (CMS) said: “…for the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.”

Today, VBP in Medicare has been expanded to include inpatient hospital services, as well as the services that physicians provide Medicare patients. The Affordable Care Act (ACA) requires that VBP also be extended to nursing homes, home health care and ambulatory surgery centers, among others. VBP is also part of a much broader trend in reimbursement among public and private payers that makes providers more financially accountable for the quality and cost of care they provide.

This chapter explains Medicare VBP for inpatient hospital services and physician services. It also summarizes the activities of private payers and commercial insurers in value-based care.

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Value-based Purchasing for Inpatient Hospital Services

Acute care hospitals receive payment adjustments under VBP based on how closely they follow a specific set of clinical practices, how well they improve the patient's experience, and how much they improve cost control. CMS translates their performance into payment bonuses or penalties for each hospital.

Implementation

Value-based purchasing began with value-based reporting. That is, in 2005, CMS asked hospitals to voluntarily provide data each year on their performance on a range of quality standards. This let the agency create a database for comparing a hospital’s current performance to its performance in the past.

- **Pay-for-Reporting**: In FY 2007, CMS imposed financial incentives to encourage reporting. For hospitals that did not submit this information properly—or not at all—Medicare reduced their annual market-basket price update\(^1\) by 2%.\(^2\) It is important to note that this payment incentive was tied to reporting quality data, not to whether the hospital actually performed well on the quality standards.

- **Pay-for-Performance**: In 2010, the Affordable Care Act (ACA) directed that, in addition to the paying incentives for reporting quality data, Medicare must provide payment incentives to hospitals based on how well they performed in actually meeting quality standards.

Quality Measures

Hospitals were initially judged on process-of-care measures and patient satisfaction with the care they received. Since then, Medicare added a number of patient outcome measures, which evaluate how much the overall health of patients improved or changed. Medicare also added one cost measure and will add more in future.

The measures for Fiscal Year (FY) 2015 (which began October 1, 2014) evaluate the:

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\(^1\) The market basket is an annual inflation adjustment to hospital Medicare payments based on projected increases in providing care.

\(^2\) CMS Press Release, 4/12/06, “FY 2007 Hospital Inpatient Prospective Payment System Proposed Rule”
Clinical Process of Care: 13 measures
Patient Experience of Care: 8 measures
Patient Outcomes: 5 measures
Efficiency/Cost: 1 measure

The medical conditions that these measures encompass are:

- Heart attack
- Heart failure
- Pneumonia
- Complications of surgery
- Conditions acquired during the patient’s hospital stay

Medicare will use these measures to judge the hospital’s performance in treating patients with these conditions. To view the full set of FY 2015 measures, see the Attachment. Keep in mind that Medicare usually adjusts measures, or adds or removes measures, each year, and it has made clear that it will focus more heavily on patient-outcome measures rather than clinical process measures in the future.

In calculating a hospital’s performance, Medicare awards points both for individual achievement in meeting the standards as well as improvement.

- Achievement: An individual hospital’s performance is compared to the performance of all hospitals during a baseline period.
- Improvement: An individual hospital’s performance is compared to that same hospital’s performance from the baseline period.

Payment Calculation

Each hospital gets points for how well it scored on each measure. Medicare then factors these into a standard formula which produces specific payment adjustments for each hospital. Those hospitals that perform well receive a payment bonus; those that do not face a penalty. The total available funds for value-based payments in FY 2015 is about $1.4 billion.

The payment incentives are especially important to hospitals because the funds that are used to pay them come from the regular fees that hospitals receive from Medicare through its Diagnosis-Related Group (DRG) system. Each year, Medicare withholding a percentage of the base operating DRG payments of hospitals participating in value-based purchasing. This applies to all DRG payments—not
just those related to the conditions covered by the quality measures. Medicare then uses that money for the incentive payments.

The reduction in DRG payments to fund the program for FY 2013 was 1%, 1.25% for FY 2014, and 1.5% for 2015.\(^3\) CMS has proposed that this rise to 2% in 2017. The law requires that the total amount of funds withheld be then used to reward hospitals for performance.

**Scope**

In understanding the impact of VBP for hospitals, several statistics help out. Medicare says that VBP affects payment for inpatient stays in about 3,000 hospitals across the US, and that, since the imposition of the financial penalties for not reporting quality performance, some 99% of all hospitals in the hospital prospective payment system are participating. As noted, also, the pool of funds for rewarding performance under VBP in FY 2015 is about $1.4 billion.

**More Information**


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\(^3\) CMS Fact Sheet, “CMS Proposals to Improve Quality of Care during Hospital Inpatient Stays,” 4/30/2014
Value-based Purchasing for Physician Services

Value-based purchasing has expanded beyond inpatient hospital care to include the services that physicians provide to Medicare patients. This includes services physicians provide in any setting.

This was mandated by the ACA which required that, by Calendar Year 2015, Medicare begin adjusting payments to physicians based upon how well they perform on a specific set of quality measures. Both cost and quality data are included in calculating the adjustment, known as the value modifier (VM). Although the program will be phased-in over several years, it will apply to all physicians by 2017.

Implementation

VBP purchasing for physician services is similar to that for hospital inpatient services, though there are some differences.

Like VBP for inpatient hospital care, the program for physicians also has two parts:

- Pay-for-Reporting
- Pay-for-Performance

How well a physician performs in any given year will be used to adjust his/her reimbursement two years later. That is, 2013 performance affects 2015 payment.

As with VBP for inpatient hospital services, physicians will receive a financial adjustment based on whether they report properly, as well as a separate financial adjustment based on how well they perform on a set of quality standards adopted by CMS.

- Thus, if a practice fails to report its performance properly in 2014, for example, it would receive a payment penalty two years later, in 2016.
- Separately, it would also receive a further payment penalty for its quality performance because, in this case, there would not be adequate data to compare its performance to that of other physicians.
Phase-In

CMS is phasing-in the financial incentives for reporting and performance over the period 2013-2017. Physician practices of:

- 100 or more were required to report in 2013, with payment adjustments in 2015;
- 10 or more must report in 2014, with payment adjustments in 2016;
- One or more must report in 2015, with payment adjustments in 2017.

Size of Adjustments

The payment bonus or penalty a physician receives varies depending upon several factors.

- Reporting: If the physician practice reports properly, it will receive a financial adjustment upwards; if not, it will receive an adjustment down. The maximum adjustments are 1.5% for 2015 and 2% for 2016. CMS has proposed increasing this to 4% for 2017.

- Performance: The payment adjustments for quality of performance are similar. The maximum adjustment is 1% for 2015 and 2% for 2016. This means payments in 2016 could go up by as much as 2% or go down by as much as 2%. CMS has proposed increasing this to 4% in 2017.

The actual amount of the adjustment a physician receives will depend upon where he or she falls across the range of quality and cost performance. Very high quality and very low cost performance would receive the maximum bonus, just as very low quality and very high costs would receive the maximum penalty. Those physicians whose performance falls near the average would receive a “neutral”—or zero—adjustment.

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4 See Medicare page on Physician Value Modifier, [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)

Quality and Cost Measures

The specific set of quality and cost measures that Medicare uses to evaluate physician performance are different from those for inpatient hospital reporting, but they cover the same general areas of patient outcomes, the costs of care, and patient opinions about the care they received.

In 2015 and 2016, the patient outcomes measures that physicians will be judged upon are:

- Readmissions for any condition
- A composite of acute prevention quality indicators (e.g., bacterial pneumonia, urinary tract infection, dehydration)
- A composite of chronic prevention quality indicators (chronic obstructive pulmonary disease (COPD), heart failure, and diabetes)

Two measures of the costs of care are used in 2015: total Medicare per-capita costs of care, and total Medicare per-capita costs for patients with COPD, heart failure, coronary artery disease, or diabetes. In 2016, the measures will also factor-in the costs for physician services that were provided three days before an inpatient hospitalization, and 30 days after.

More information

The best source for more information about the physician VBP program is on the Medicare site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

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6 Composite quality indicators are a combination of two or more quality measures in which a provider’s performance on each measure is weighed with the others and results in a single score.
Value-based Purchasing among Private Payers

VBP is also a central part of efforts by private payers to rein in costs and improve quality. Though some of these are similar to the Medicare approach for inpatient care and physician services, others are much broader.

Definitions

The terms “value-based purchasing” and “value-based care” are being used among private payers to describe a variety of efforts that, in various ways, connect the level of reimbursement to the level of quality and cost control a physician or health care facility provides. These include patient-centered medical homes, accountable care organizations, bundled payments, and pay-for-performance programs.

- **Pay-for-performance** refers to payment arrangements—like Medicare’s VBP program—in which providers receive bonuses or penalties based on whether they meet set quality or cost benchmarks.7
- **Accountable care organizations** are arrangements where physicians, hospitals, and other providers align themselves with one another to provide coordinated care and take on financial responsibility for improving overall quality and costs.
- **Bundled payments** provide a set fee for a defined episode of care in which payments for all of the providers involved in the care are included. Bundled payments include accountability for the costs and quality of the care.
- **Patient-centered medical homes** offer providers an extra fee to coordinate all of the care a patient receives, and often additional fees based on performance.

Scope

Value-based care programs of this kind are being adopted by payers in virtually all parts of the country.

- In July, 2014, the Blue Cross and Blue Shield payers announced that one in five of their reimbursement dollars—some $65 billion annually—are now tied to programs that link contracts to quality, outcomes, and cost measures. This includes arrangements with more than 215,000 physicians and covering more than 24 million beneficiaries in 49 states, Washington, DC, and Puerto Rico. Blue Cross cites success in better outcomes, better cost control, and more appropriate utilization.

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A 2014 report by the RAND Corporation reviewed the performance of value-based care efforts among private payers throughout the country. RAND’s review encompassed more than 100 individual programs that private payers now operate, including pay-for-performance contracts, accountable care arrangements, and bundled payment programs covering inpatient, ambulatory, and nursing home care.

**Top Things to Know about Value-based Purchasing**

1. Value-based purchasing bases reimbursement on the quality and cost of care that physicians and hospitals provide.

2. Medicare and private payers use measures of quality and the cost of care to judge the provider’s performance, and then translate that into incentive payments that can increase or decrease a provider’s revenue.

3. Value-based purchasing is now functioning in Medicare inpatient hospital services and physician services for Medicare patients. It is also expanding to include Medicare reimbursement for services in nursing homes, home health agencies, and other settings.

4. Value-based purchasing is being used widely by private payers.

5. Value-based purchasing will influence a significant amount of reimbursement, so its incentives will likely have a significant impact on provider behavior and performance.

6. Value-based purchasing is part of a much broader effort among public and private payers to hold providers financially accountable for the quality of care they provide, as well as the costs.

7. Value-based purchasing, as well as Medicare’s efforts to reduce readmissions and hospital acquired conditions, focus on several common conditions: heart attack, heart failure, pneumonia, surgical complications, and infections.
## Fiscal Year 2015 Quality Measures

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