Maximizing the Return on Your Value-Based Mission

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June 4, 2015

Outline

- What is value-based purchasing – and why should we care?
- Responding to value-based purchasing
- The Big Picture
- Questions and discussion

WHAT IS VALUE-BASED PURCHASING (VBP)?

The Theory of VBP

- Agency for Healthcare Research and Quality (AHRQ) Report: "The concept of value-based healthcare purchasing is that buyers should hold providers of healthcare accountable for both cost and quality of care."
- In an era of intense cost containment pressures, VBP creates the opportunities for "win-win" if providers can save money by reducing unnecessary utilization.
- VBP is often contrasted with fee-for-service (FFS), with all of its putative evils, including the encouragement of overuse.
- However, most VBP systems are based on FFS models, with a quality or performance "kicker."

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Secretary Burwell – January 26, 2015:

"HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. ***HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018*** through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments."

Continuum of VBP Models

Level 0

FFS + bonus and/or withhold based on quality scores

Level 1

FFS + upside-only shared savings when outcome scores are sufficient
(For PCMH/APC, FFS may be complemented with PMPM subsidy.)

Level 2

FFS + risk-sharing
(upside available when outcome scores are sufficient)

Level 3

Only feasible after Level 2; requires mature performing provider system (PPS)
*Prospective capitation PMPM or bundle *(with outcome-based component)*

Some Concerns/Issues with VBP

How do we define "value," and who gets to define it?

- Different payers use different metrics
- Problems with risk and other adjustments
- Particular problems with adjustment for socioeconomic status
- Conceptual/intelligent difficulties with the metrics in the first place

DATA: how good is it, how timely is it, and who owns it?

- Problems with Medicare ACOs

Underlying intellectual framework: better quality = lower costs

- This is sometimes true, but as a general rule, it is demonstrably false.

Or is this just how payers are going to sugarcoat payment cuts?

RESPONDING TO THE NEW ERA

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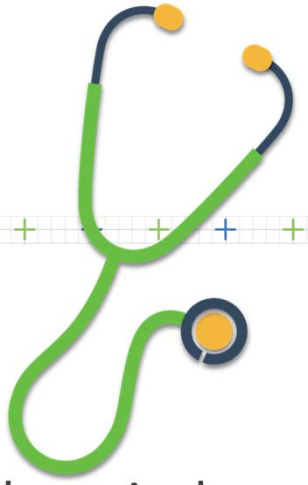
Rule #1: Reduce Your Costs

- Neither public nor private payers intend for VBP to be a mechanism to pay you more money.
  - And if VBP flops, they'll find other ways to cut
- In a time of significant uncertainty, there's no substitute for cash.
- In its most extreme form, VBP gives payers a club with which to direct where you should reduce your costs (and revenues). Take control of your budgetary processes.

Rule #2: Data is a Strategy, Not an Overhead Expense

- While expensive and troublesome, EMRs are the least of it.
- Data management is for techies; information management will be an increasingly central strategic tool.
- You will increasingly need to know where your costs are, which of your patients incur which costs, and where your margins really come from. And VBP does—dramatically—change the rules about that.

Rule #3: Work With Your Docs

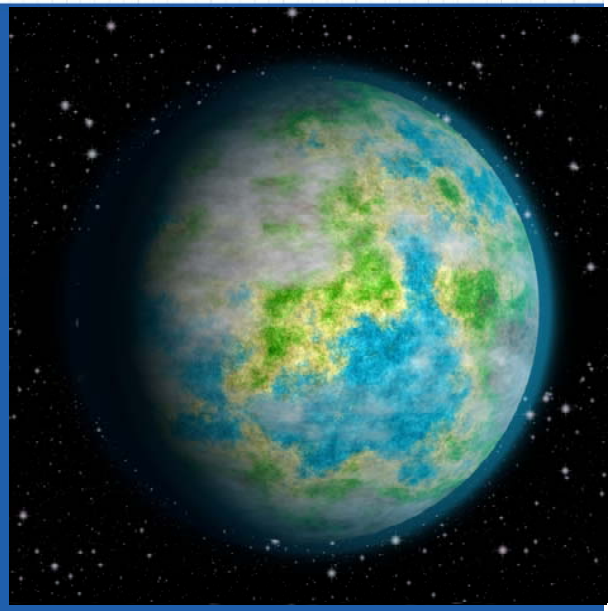


- In the world of VBP, you and your docs will succeed or fail together.
- As more and more of what used to happen only for hospital inpatients gets moved outside, your docs will either be your partners or your competitors—and sometimes both.
- Remember that—at the moment, in most communities—the docs are just as scared and confused as you are; address that directly.
- A well-organized medical staff with effective leadership is your greatest potential ally and asset, even though it may often feel like a pain in the butt.

Rule #4: Make Your Patients Happy

- VBP performance measures will increasingly include measures of patient satisfaction, even though those measures are frequently inadequate and poorly correlated with clinical quality.
- As government payers increasingly move toward VBP, the support of your patients will become a more important political asset.
- As employers' private payers increasingly push toward exchange-based insurance purchasing, consumer brand loyalty will be an essential and irreplaceable asset.

THE BIG PICTURE



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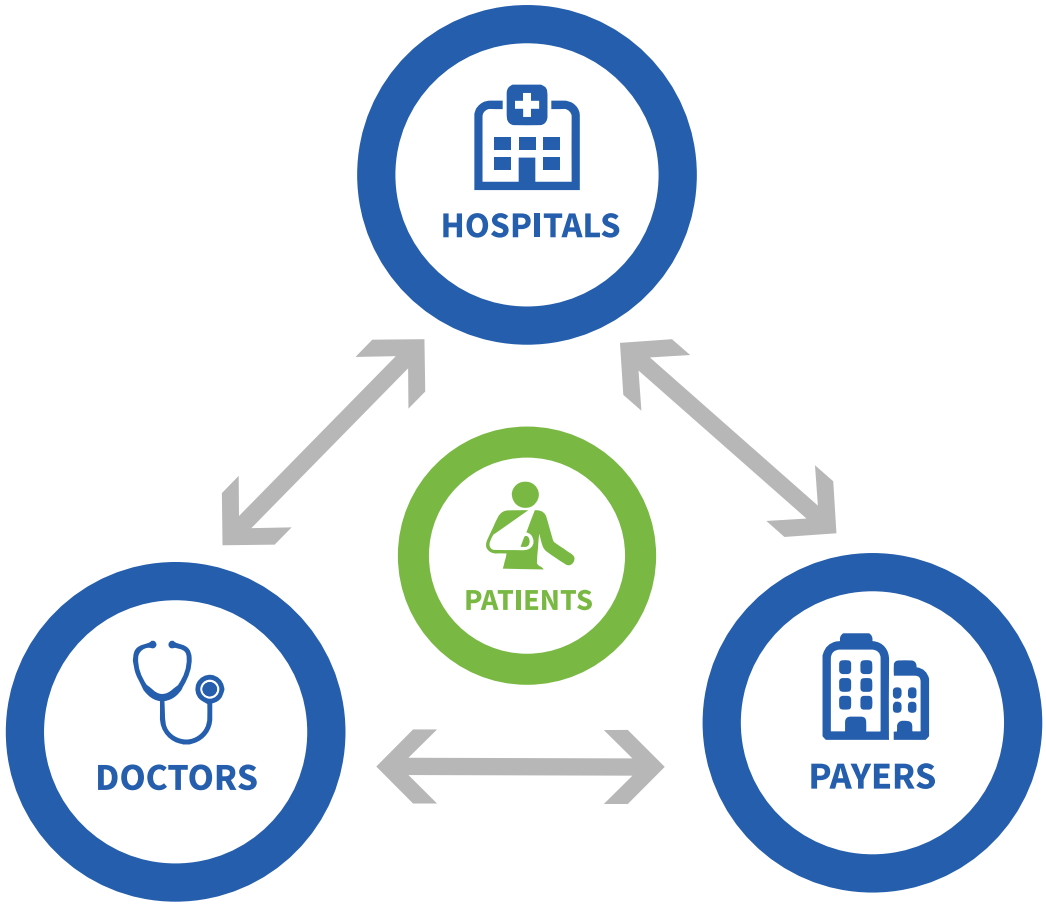
Per person served, revenue growth in excess of CPI is a thing of the past.

- No near-term easing of public sector budgets, while number of Medicare and Medicaid enrollees will continue to increase
- Privately insured, middle-income Americans are increasingly having trouble paying for their coinsurance and deductibles
- Inpatient utilization (per capita, age-adjusted) will continue to fall
- Growing pressure to move expenditures on end-of-life care outside the hospital

Despite flat revenues, expectations and demands will continue to rise.

- Data and reporting will continue to consume an increasing share of organizational budgets
- Push for transparency will make more and more data about hospital operations, finances, and prices public—and you will need to make sure that data is accurate (in some cases, to change policies that produce embarrassing data)
- The influence of the Internet and social media will continue to raise public expectations about what medicine can accomplish

The Macropolitical Equation



Two Out of Three Wins!

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Responding to Value-Based Purchasing

1. Reduce your costs
2. Data is a strategy, not an overhead expense
3. Work with your docs
4. Make your patients happy

Thank you.

QUESTIONS?

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