

American healthcare system essay sample

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As a result of the Patient Protection and Affordable Care Act of 2010, beginning in October 2012, US hospitals will begin having their payments from Medicare affected by the Hospital Value-Based Purchasing Program. Essentially, this legislation will shift the way hospitals are reimbursed for services from a focus on quantity to a focus on quality. The following research study will examine the background of this legislation, how it is structured, and the pros and cons of this reform. Currently, hospitals are paid a flat fee per hospital case by the federal Medicare program, using the Inpatient Prospective Payment System (IPPS). The prospective payment price, also referred to as the DRG (Diagnosis Related Groups) payment, covers all hospital costs for treating the patient during a specific inpatient stay, including the costs of all devices that are used. CMS adjusts DRG payments annually to reflect changes in hospital costs and changes in technology.

This fee is paid to the hospital based on the patient's symptoms, age, sex, discharge status, and the presence of complications, but does not account for length of stay or how many hospital services are actually used. (Ellis, 2011) Over time, the attempt has been to keep these rates close to the average cost of providing the services per case, although many hospitals claim that often the case payments they receive are below their own full costs. (Reinhardt, 2009) In October 2012, the Centers for Medicare and Medicaid Services (CMS) is implementing the Hospital Value-Based Purchasing (VBP) Program. This initiative will reward acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare. This means that DRGs are still in place, but incentives can be

reached based on how well the hospital performs on certain quality measures, or how much the hospital's performance improves compared to its performance during a baseline period. There are 25 measures that determine performance, including: patients' communication between physicians and nurses, hospital staff responsiveness, patients' pain management and hospital cleanliness. The higher the performance, the higher the incentive payment will be. (Ellis, 2011) This regulation is causing much contention, as CMS has never before tied payment to a facility's performance on quality care more than quantity.

Performance and patient satisfaction measures are not new concepts, and actually have been around for quite some time. In 2003, CMS and Premier, Inc. (a national group purchasing organization and alliance of more than 2,400 US hospitals and over 70,000 other health care sites) initiated the Premier Hospital Quality Incentive Demonstration (HQID), a voluntary pay-for-performance program. In the first year of the project, 260 hospitals participated. According to Premier, the HQID value-based purchasing project raised the overall quality in the participating hospitals by an average of 18.6 percent over six years. This figure was based on their delivery of more than 30 nationally standardized and widely accepted care measures to patients in six clinical areas: acute myocardial infarction (AMI), heart failure, community-acquired pneumonia, coronary artery bypass graft (CABG), hip and knee surgery, and ischemic stroke.

Additional research by Premier using the Hospital Compare dataset showed that, by September 2009, HQID participants scored on average 5.44

percentage points higher (95.64 percent to 90.2 percent) than non-participants on 25 performance measures used by Hospital Compare, the government's scorecard for hospital quality. After the sixth and final year of the project, CMS announced that it will award incentive payments of almost \$12 million dollars to 211 providers for top performance, as well as top improvement in the project's six clinical areas. (Premier, 2012) Following this first leap into the concept of pay-for-performance, HCAHPS (Hospital Consumer Assessment of Health Providers and Systems), a government survey for measuring patient satisfaction at hospitals across the country, was introduced in October 2006. CMS and the Agency for Healthcare Research and Quality (AHRQ) sponsored the survey.

The categories focus on communication with doctors and nurses, responsiveness of hospital staff, pain management, cleanliness and quietness of the hospital environment, and instructions about medications and discharge. This information has been publicly available via the Hospital Quality Alliance Web site (www.hospitalcompare.hhs.gov) since late March 2008. On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. Though this law has multiple provisions that are currently being disputed and legally challenged, one thing is certain; healthcare in America is changing. This new law addresses several healthcare-related issues, including expanding coverage, controlling health care costs, and improving health care delivery systems. (Kaiser Family Foundation, 2011) It is certainly understandable why healthcare reform is necessary. In 2000, the United States spent more on

health care than any other country in the world: an average of \$ 4, 500 per person. Switzerland was second highest, at \$3, 300 or 71% of the US.

Although the US leads the world in healthcare spending, average US life expectancy ranks 27th in the world, at 77 years. Many countries achieve higher life expectancy rates with significantly lower spending. For example, with a life expectancy of 76. 9 years, Cuba ranks 28th in the world, just behind the US. However, its spending per person on health care is one of the lowest in the world, at \$186, or about 1/25 the spending of the United States. (UC Atlas of Global Inequality, 2011) One of the fundamental goals of payment reform is to reduce Medicare spending by approximately \$214 billion over the next ten years. (Kouyoumdjian-Gurunlian, 2012) Building on the HQID and HCAHPS hospital quality initiatives, the Patient Protection and Affordable Care Act of 2010 will take quality measures one step further; it will directly tie these measures to financial payments made to hospitals. Beginning in October 2012, HCAHPS scores will be among those measures used to calculate provider reimbursement under the new CMS Value-Based Purchasing (VBP) system. (Kouyoumdjian-Gurunlian, 2012) According to CMS, “ the Affordable Care Act of 2010 requires the Secretary of the Department of Health and Human Services (HHS) to establish a value-based purchasing program for inpatient hospitals.

To improve quality, the Affordable Care Act builds on earlier legislation—the 2003 Medicare Prescription Drug, Improvement, and Modernization Act and the 2005 Deficit Reduction Act. These earlier laws established a way for Medicare to pay hospitals for reporting on quality measures, a necessary

step in the process of paying for quality rather than quantity.” (CMS, 2012)

In order for Value Based Purchasing to be successful, data must be reliable and comprehensive. According to the National Business Coalition on Health, a national, non-profit, membership organization of purchaser-led health care coalitions, there are “ Four Pillars of Value Based Purchasing”: (1)

Standardized Performance Measurement. Standardized performance measurement is the foundation upon which value based purchasing rests. There is no capacity to reward excellence in health care without first measuring performance.

They cite priority areas for measurement, including consumer behaviors (such as healthy lifestyle choices and management of chronic diseases), medical services and interventions, and health plan / hospital / practitioner performance. There are currently many national organizations that are working on standardizing performance measures of hospitals, including AHRQ (Agency for Healthcare Research and Quality), NCQA (National Committee for Quality Assurance) and JCAHO (Joint Commission on the Accreditation of Healthcare Organizations). (2) Transparency and Public Reporting. The second pillar in value based purchasing according to NBCH is full transparency and public reporting. Standardized performance measures need to be converted into useful information for purchasers (hospitals), payers (insurance companies and the government) and consumers. If information regarding performance is readily available, these resources can help consumers make more informed decisions regarding their healthcare. (3) Payment Reform. The third pillar of value based purchasing is payment reform. There are two critical aspects of payment reform: first, the principle

of differential reimbursement based on performance; the second, the need to redesign payment methodology to better align economic incentives with desired outcomes.

Whether these approaches or others, a pillar of value based purchasing should be experimentation with different payment methodologies to better encourage high quality, efficient services and new models of care delivery.

(4) Informed Choice. The final pillar of value based purchasing is informed choice. Performance information, including quality data and cost information, is often reported to consumers as a result of a focus on health care transparency and consumerism. Consumers can access data online through various provider performance resources, such as HealthGrades, in addition to health plans' websites. Studies support reporting performance information to consumers to help encourage informed health care decision-making. (NBCH, 2011) Will CMS adopt the concepts from these pillars? It will certainly be beneficial for all parties involved, and it will take groups like NBCH to lead both the private and public sectors to demand quality data and information upon which our current laws are being formed. Through the Hospital Value-Based Purchasing Program, CMS is changing the way it pays hospitals, rewarding hospitals for the quality of care they provide to Medicare patients, not just the quantity of procedures they perform.

Hospitals are rewarded based on how closely they follow best clinical practices and how well hospitals enhance patients' experiences of care.

(CMS, 2012) CMS has defined the following goals for the Medicare Hospital VBP program: (1) Improve clinical quality (2) Reduce adverse events and

improve patient safety (3) Encourage more patient-centered care (4) Avoid unnecessary costs in the delivery of care (5) Stimulate investments in structural components or systems such as IT capability and care management tools and processes that have proved effective in improving quality and efficiency (6) Make performance results transparent and comprehensible so that consumers can be empowered to make value-based decisions about their health care and to encourage hospitals and clinicians to improve the quality of care. (CMS, 2012) CMS will score hospitals using two different methodologies. 70 percent of a hospital's total performance score will be based on 17 clinical processes of care and outcomes measures that are pre-determined. The remaining 30 percent of the VBP payment will be based on a patient experience score as determined through a survey. CMS will use the HCAHPS survey that was previously discussed, which contains 18 core questions about critical aspects of patients' hospital experiences.

These items include communication with nurses and doctors, responsiveness of hospital staff, cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information and overall rating of the hospital. The random survey is administered to a sample of adult patients across medical conditions between 48 hours and six weeks after discharge and is not restricted to Medicare beneficiaries. The scores will be given weights of 70% and 30% respectively, and will determine a hospital's Total Performance Score (TPS). TPS will determine incentive payments. Incentives will be based both on specified quality thresholds (hospitals will have to perform better than half of all hospitals during the performance period) and improvement on the hospital's own performance

(baseline established from July 2009 to March 2010) where the higher of the two scores will be considered. The largest incentives payments will be made to the top scoring hospitals, and will decrease for lower TPS scores.

(Capgemini Consulting, 2011) In 2014, CMS proposes to expand the VBP program to add three risk-standardized mortality measures, eight hospitals acquired condition measures, and nine AHRQ Patient Safety Indicator and Inpatient Quality Indicator (IQR) outcome measures. (Capgemini Consulting, 2011) In order to fund payment for these incentives, hospitals participating in VBP will have their base operating DRG payments reduced by a small percentage each year.

The base operating DRG percent reduction is 1 percent for Fiscal Year (FY) 2013, 1.25 percent for FY 2014, 1.5 percent for FY 2015, 1.75 percent for FY 2016, and 2 percent for FY 2017 and subsequent years. (CMS, 2012)

Because DRG payments will be reduced, hospitals will need to adapt and make significant changes in order to capture incentive payments. Many facilities will be negatively affected if they do not introduce sustainable measures to ensure that they are meeting or exceeding the new quality guidelines. (Kouyoumdjian-Gurunlian, 2012) As previously stated, the essence of value-based purchasing is to pay for results instead of units of care. I believe that most people would agree that this concept is good; let's reward hospitals who generate superior outcomes, and give poor performing hospitals a real incentive to improve. I believe there's also no doubt that our current payment system needs an overhaul, as it is based on rewarding all providers equally, regardless of whether they are doing a good job of providing care or not. I know that I would much rather receive treatment for

myself or someone in my family at a facility that was focused on positive outcomes rather than seeing as many patients as possible. However, there may be some unintended negative consequences to this legislation. As an example, “patient satisfaction” is clearly something that we all want.

It is desirable to have hospitals that are clean and quiet, and to have doctors, nurses and others communicate with us clearly and completely. Keeping people out of pain in the hospital is also the right thing to do, but sometimes it comes into conflict with efforts to monitor how often doctors prescribe narcotics. (Freeman, 2012) A recent New York Times article illustrated the difficulty emergency room doctors have in diagnosing pain-related ailments. A drug addict can present themselves in an ER complaining of dental pain and demand a narcotic, but the ER doctor has no way of truly diagnosing the problem. Since the new quality measures will include patient satisfaction, does the ER doctor prescribe a narcotic to treat the pain, or withhold narcotics to intervene and potentially help a drug addict? Dr. Tom Benzoni, an emergency physician who has worked for 18 years at Mercy Medical Center in Sioux City, Iowa, who is routinely rated on patient satisfaction and sometimes asked by management to explain a bad review, said that he feels at times as if he faces a no-win choice. “If you’re going to criticize me for not giving out narcotics, and you never praise me for correctly identifying a drug-seeker,” he said, “then I’m going to give out narcotics.” (Saint Louis, 2012) Another article in the Journal of the American Medical Association cites the dilemma for doctors who are willing to take on patients with chronic pain and possible narcotic abuse and work to get patients off of narcotics where possible.

Patients may be frustrated or angry when they do not receive the treatment they want and have a misperception that receiving the treatment they want equals good medical care. Physicians who comply with unreasonable requests may find themselves in the role of “customer service” providers rather than medical professionals or healers. Additionally, physicians who do not comply with patient requests may be the recipients of poor ratings on patient satisfaction scores, possibly resulting in emotional, financial, and professional penalties. (Zgierska, Miller & Rabago, 2012) Another unintended consequence may be the effect on hospitals located in poorer communities. Typically, these hospitals are county or state funded, and provide disproportionate care to poor, uninsured, and generally medically underserved people. Because they rely on public funding and provide a greater percentage of indigent care, they typically are not among those that already have a robust bottom line, thus they do not have the means to invest in the equipment and process changes needed to be the “winners” in VBP.

They are also likely to have a lower percent of Medicare patients, in part because once people, even poor people, receive Medicare they are no longer uninsured, and they can and sometimes do go to hospitals perceived as “better”. (Freeman, 2012) Generally, larger and financially successful hospitals are very good at modifying their behavior in response to economic incentives. Unfortunately, this could mean that the better hospitals could avoid patients who may put them at risk. As Freeman states in his blog, Medicine and Social Justice, “Hospitals (the “high end” ones) are already trying to figure out how they can divest themselves of Medicare patients, on

whom they already make less money, and replace them with patients with better insurance. To the extent that they are successful, it will just add Medicare recipients to the growing list of “less desirable” patients.”

(Freeman, 2012) Additionally, patients in poorer communities might be less likely to adhere to treatment recommendations, which would result in lower scores.

For example, they might be less likely to obtain preventive care such as mammograms and Pap smears, or less likely to return for follow-up of abnormal results because of problems with transportation and child care or difficulty comprehending the recommendation. If compared directly to physicians in wealthier areas, physicians in poor minority communities might be less likely to receive incentive pay and more likely to be listed in public report cards as poor-quality physicians. (Casalino, Elster, Eisenberg, Lewis, Montgomery & Ramos, 2007) Increased risk for providers also needs to be considered. A document assembled by Capgemini Consulting, one of the world’s foremost providers of consulting, technology and outsourcing services, points out a very valid illustration using the occurrence of a “never event”: “For example, a wrong blood type might be given to a patient because of incorrect labeling by the blood bank. The hospital intrinsically is not at fault, in this example, but will be penalized nevertheless. Research by the Irving, Texas based VHA Inc. (Voluntary Hospitals of America) shows that 75% of all hospitals covered under VBP stand to lose under the new measures.

The research calculated a national median VBP score of 53 when hospitals will need scores higher than 70 to maximize their Medicare reimbursements. Hospitals face an average VBP revenue risk of \$888, 812 in 2012 and \$6. 67 million over five years.” (Capgemini Consulting, 2011) Another challenge that providers are facing is the aggressive timeline for implementation of this new program. The Affordable Care Act establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals by the end of 2012. Payments in 2013 will be based on performance from July 2011 to March 2012. Medicare will link financial incentives or penalties to quality outcomes under this program. Thus, the providers have little time to prepare for improving quality of outcomes and its subsequent reporting.

Hospitals will have to develop a transition strategy to move from a volume-based to a value-based payment system, a strategy that will take a considerable amount of time to develop and implement. (Capgemini Consulting, 2011) In conclusion, there are clearly several factors to consider as we determine whether Value Based Purchasing will be a success. There are many issues that are sure to arise as hospitals face the reality of reduced DRGs and a comprehensive pay for performance model. As this initiative is only one aspect of healthcare reform, hospitals are undoubtedly overwhelmed with prioritizing and implementing changes. The fundamentals and background of this concept are sound, and only time will tell if our healthcare system can truly be reformed by improving performance while, at the same time, reducing costs. In the end, all parties will benefit if we are successful.

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