

ANNALS OF HEALTH LAW
Advance Directive

VOLUME 20 SPRING 2011 PAGES 134-143

Value-Based Purchasing As a Bridge Between Value and
Access

*Erin Lau**

I. INTRODUCTION

By definition, the words “value” and “access” seem to have little correlation. Value quantifies monetary cost by considering the worth of the service or product without regard for accessibility to that service or product.¹ Similarly, “access” by its definition is unconcerned with value. Access is “the freedom or ability to make use of something.”² The words “freedom or ability” connote two dimensions of health care access: potential access and actual access.³ Potential access is the health care that is available to the patient-consumer.⁴ Actual access is the health care that is obtained.⁵ Neither dimension of access addresses the cost concern fundamental to the definition of “value.” Despite this apparent dichotomy between value and access, recent reform efforts propose the notion that value can increase access in the realm of health care.

The purpose of this article is to explore the effect of value on access to health care by examining Medicare’s proposed rules for a value-based purchasing program (VBP

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2012. Ms. Lau is a staff member of *Annals of Health Law*.

1. *Value Definition*, MERRIAM-WEBSTER, <http://www.merriam-webster.com/dictionary/value> (last visited Feb. 21, 2011).

2. *Access Definition*, MERRIAM-WEBSTER, <http://www.merriam-webster.com/dictionary/access> (last visited Feb. 21, 2011).

3. See LU ANN ADAY ET AL., EVALUATING THE MEDICAL CARE SYSTEM: EFFECTIVENESS, EFFICIENCY, AND EQUITY 126 (1993). “Actual access” and “potential access” have also been described in health care literature as “utilization” or “revealed access” and “accessibility” respectively. *Id.* See also Lin, Swu-Jane, *et al.*, *Potential Access and Revealed Access to Pain Management Medications*, 60 SOC. SCIENCE & MED. 1881, 1881 (2005).

4. *Id.*

5. *Id.*

program).⁶ First, this article will summarize the proposed rules for the implementation of the VBP program.⁷ Next, this article explores how the VBP program may increase actual and potential access to health care.⁸ Finally, this article discusses a criticism that the VBP program may actually decrease access to health care.⁹ Ultimately, this article concludes that the VBP program will likely increase access to health care.¹⁰ Please note that although CMS released the Final Rule for the VBP program at the time this article was published, it was not at the I initially wrote the article. Due to time constraints, this article will not focus on the Final Rule, but only the Proposed Rule and its specifics.

II. THE VBP PROGRAM FIXES PAYMENT ON PERFORMANCE MEASURES

On January 13, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposal for the implementation of the VBP program for hospital inpatient services.¹¹ The VBP program was authorized by Section 3001(a) of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA).¹² Hospitals eligible to participate in the VBP program include those hospitals in the fifty states and the District of Columbia that are currently reimbursed under the Acute Care Inpatient Prospective Payment System (IPPS).¹³

The purpose of the VBP program is to reorient CMS' method of reimbursement from paying for volume to paying for value, results, and innovation.¹⁴ The VBP program achieves this objective by giving incentive payments for achievement and improvement based on a performance score.¹⁵ These incentive payments will apply to discharges on or after October 1, 2012.¹⁶ Participating hospitals are further motivated to receive a high

6. Medicare Program; Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454 (proposed Jan. 11, 2011) (to be codified at 42 CFR pts. 422, 480).

7. See discussion *infra* Part II.

8. See discussion *infra* Part III.

9. See discussion *infra* Part IV.

10. See discussion *infra* Part V.

11. Medicare Program; Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. 2454, 2454 (proposed Jan. 11, 2011) (to be codified at 42 CFR pts. 422, 480).

12. *Id.* at 2454, 2457.

13. *Id.* at 2479.

14. *Id.* at 2455.

15. *Id.* at 2457.

16. *Id.* at 2454.

performance score because Section 5001(a) of the Deficit Reduction Act of 2005 further decreased the annual percentage a participating hospital received by two percentage points.¹⁷ The VBP program is based upon the Medicare Hospital Quality Reporting Program (Hospital IQR Program), which provides financial incentives to report specific quality measures.¹⁸ Under the proposed rules, eighteen quality measures from the Hospital IQR Program are used to determine a hospital's performance score.¹⁹

In general, the eighteen quality measures are categorized into two domains: clinical process of care and patient experience of care.²⁰ Clinical processes of care measures include: the treatment of heart failure, pneumonia, acute myocardial infarction, and healthcare-associated infections.²¹ Measures of patient experience of care are based on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey.²² Each domain has a separate calculation for an achievement and improvement score.²³ After the domain score is calculated, the domain is weighted by an equation, first the clinical process domain score is multiplied by .7, then the patient experience of care domain is multiplied by .3.²⁴ Finally, the sum of all of the weighted domain scores results in the hospital's performance score.²⁵ The performance score is then translated using a linear exchange function that will determine the percentage of the VBP incentive payment the hospital earned.²⁶

III. EFFECTS ON INCREASED POTENTIAL AND ACTUAL ACCESS

The VBP program may increase actual access and potential access to health care in at least three different ways. First, the value-based health care theory of health care

17. *Id.* at 2456.

18. *See id.* at 2457 (The results of the Hospital IQR program can be found at www.hospitalcompare.hhs.gov).

19. *Id.* at 2457.

20. *Id.* However, in 2013 a third domain "outcome measures" will be taken into account. *Id.* at 2466. The measures for this domain have yet to be determined. *Id.*

21. *Id.* at 2462.

22. *Id.* HCAHPS is a national standardized survey and data collection developed by CMS, the Agency for Healthcare Research and Quality (AHRQ) and the Department of Healthcare and Human Services to measure patient experience. HCAHPS: PATIENTS' PERSPECTIVES OF CARE SURVEY, <https://www.cms.gov/HospitalQualityInits/>

30_HospitalHCAHPS.asp (last visited May 13, 2011).

23. *Id.* at 2467, 2472.

24. *Id.* at 2457.

25. *Id.*

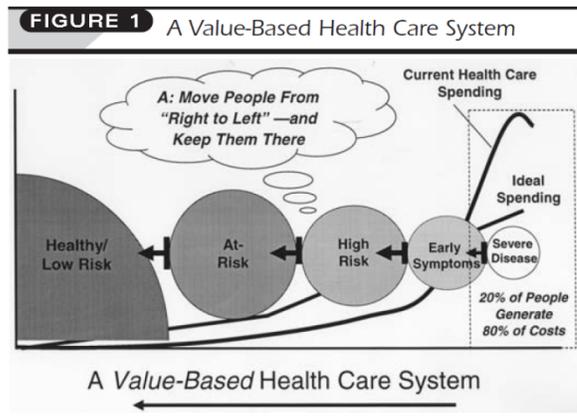
26. *Id.* at 2466.

delivery encourages the majority of beneficiaries to utilize services because the theory seeks to create a more equitable distribution of services.²⁷ Second, those services will be more accessible to those beneficiaries because participating hospitals are incentivized to improve and provide those services.²⁸ Finally, the VBP program increases potential access by encouraging beneficiaries to become informed on the treatments they should seek through the discharge instruction measure.²⁹

a. VBP increases actual access based on the Value-based health care theory

The value-based health care theory of health care delivery generally promotes a more equitable distribution of resources,³⁰ which increases access to health care because more services can be provided the majority of those who require preventative services.³¹ Currently, only twenty percent of people generate eighty percent of healthcare

spending.³² Figure 1 depicts this disparity by showing the populations of patients based on their risk for severe disease.³³ The steep “Current Health Care Spending” slope represents where the most spending occurs; the higher the line the more is being spent on that population.³⁴ This creates a steep slope that illustrates the disparity of the spending distribution



within the different patient populations – the more severe the disease, the smaller the population, and the greater the expense.³⁵ Value-based health care seeks an equitable distribution of resources by spending across all patient groups through incentivizing

27. See discussion *infra* Part III A.

28. See discussion *infra* Part III B.

29. See discussion *infra* Part III C.

30. Margaret E. O’Kane, *Performance-Based Measures: The Early Results Are In*, 13 J. MANAGED CARE PHARMACY S3, S4 (March 2007).

31. See *Id.*

32. *Id.*

33. *Id.* at S3.

34. *Id.*

35. *Id.* at S4, Fig. 1.

quality care and innovation for all patients and not just the seriously ill.³⁶ In sum, value-based health care seeks to decrease the slope of the spending distribution, as illustrated by the “Ideal Spending” line, thereby increasing access to health care across all populations.³⁷ Similarly, the VBP purchasing program will be evaluated to determine whether it affects access to care for Medicare beneficiaries.³⁸ Yet, based on the proposed rules, the slope of the ideal spending line may not result in a drastic decrease.

In Figure 1, the slope of the Ideal Spending Line is a gradual slope that reflects uniform spending based on the severity of the disease.³⁹ Although the Ideal Spending Line displays a significant decrease in spending for severe diseases from the Current Health Care Spending line,⁴⁰ the VBP program may not achieve the Ideal Spending Line in Figure 1 due to its source of funding. While value-based purchasing theory’s Ideal Spending Line achieved through reducing spending on patients with severe disease and increasing spending on the majority of patients, which are those patients with less severe diseases, the VBP program will be funded by a reduction in the base operating Diagnosis Related Groups’ (DRG) payment for each hospital.⁴¹

Base operating DRG is the payment operating costs of inpatient hospital discharge services,⁴² which is predicted to be reduced to create \$850 million in funds for the VBP program.⁴³ Therefore, under the VBP program the difference between ideal spending and current health care spending will be influenced by the population of patients that use the most inpatient hospital discharge services because they are the patients creating the base operating DRG payments. If the base operating DRG payments are mostly used by the eighty percent patient population, then the difference between ideal spending and current health care spending may not change much from Figure 1. However, if the base

36. *Id.* at S3.

37. *Id.*

38. *See* Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2485.

39. O’Kane, *supra* note 30, at S4.

40. *Id.*, Fig. 1.

41. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2487. Diagnosis Related Groups is a reimbursement system that pays hospitals at a predetermined rate based on the patient’s diagnosis. Rick Mayes, *The Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System*, 62 J. OF THE HIST. OF MED. AND ALLIED SCI. 1, 1 (2006).

42. 42 U.S.C. 1395ww (d) (2011).

43. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2490. PPACA defines base operating DRG as the payment made under 42 U.S.C. 1395ww subsection (d). Patient

operating DRG payments are mostly utilized by the twenty percent that use the most resources, then the disparity between ideal spending and current health care spending would decrease in accordance with the value-based purchasing theory lines because it would shift funds to remaining eighty percent of the population.⁴⁴ Subsequently, actual access would increase because the eighty percent of patients who do not use most of the resources would receive services they previously did not receive because the resources were spent on the twenty percent with severe diseases.⁴⁵ Access is further increased because hospitals are incentivized to provide those services under the VBP program.

b. The VBP Program increases access by improving and providing more services

The VBP program increases actual access to health care services by financially incentivizing hospitals to provide and improve certain medical services.⁴⁶ Under the proposed rules, if a participating hospital fails to achieve a certain threshold for a quality measure or improve their performance for a quality measure, then will not earn achievement or improvement points.⁴⁷ If the hospital doesn't earn achievement or improvement points, then it will not be able to add to that measure's domain.⁴⁸ Therefore, if a participating hospital fails to earn achievement points or improvement points, then the hospital will not be able to receive the VBP financial incentive payment because the domain amount determines the payment amount.⁴⁹

For example, if a participating hospital fails to achieve the threshold improvement score for providing a pneumococcal vaccination, it would receive zero points for that quality measure.⁵⁰ Receiving zero points for a quality measure would drastically affect a hospital's incentive payment because the incentive payment is based on the hospital's performance score, which is the sum of the weighted achievement scores.⁵¹ Simply put, the VBP program incentivizes participating hospitals to improve overall quality or

Protection and Affordable Care Act, Pub. L. No. 111-148 & 111-152, § 3001 (2010).

44. See O'Kane, *supra* note 30, at S4.

45. *Id.*

46. See Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2457.

47. *Id.* at 2467, 2472.

48. *Id.*

49. See *id.* at 2457.

50. *Id.* at 2469.

51. *Id.* at 2457.

maintain high performance in the areas measured by the VBP program because its incentive payment is based on all applicable scores.⁵² A hospital cannot game the system by only improving one measure to the detriment of other measures because the financial incentive will be determined based on the aggregate scores of the services that hospital provides.⁵³ Furthermore, because the financial incentive is based on an aggregate score, a hospital can spread the risk of not receiving payment by providing several of the services that are measured. A hospital would be further incentivized to being to provide services that were previously not provided because the improvement score would be great.⁵⁴ Therefore, the VBP program encourages hospitals to improve or provide the services that the VBP program measures to receive or increase incentive payments. These increases in quality and services will subsequently lead to an increase in access to health care.

c. Discharge instructions would increase potential access to health care

Finally, the VBP program increases access to health care through the provision of discharge instructions for heart failure. Discharge instructions are directions and information for patients to manage their own care after leaving the hospital.⁵⁵ The provision of discharge instructions for heart failure is one of the eighteen quality measures that determine a hospital's performance score and subsequently its financial payment.⁵⁶ Incentivizing the provision of discharge instructions for heart failure increases potential access to self-care and preventative care for those patients and open beds for others because studies show a positive relationship between the provision of discharge instructions and a reduction in readmission rates.⁵⁷

52. *See id.*

53. *See id.* at 2470 (describing the calculation of the domain score based on the aggregate of applicable measure scores).

54. *See id.* at 2467 (describing the calculation for the improvement score. A hospital performance period score would not be reduced by the baseline period score because the hospital that started providing a new quality measure would not have a baseline period score).

55. Zeng-Treitler, Qing, et al., Improving Patient Comprehension and Recall of Discharge Instructions by Supplementing Free Texts with Pictographs 849 (2008) (paper presented at the 2008 American Medical Informatics Association Annual Symposium), available at PubMed PMC2656019.

56. *Id.* at 2462.

57. *See generally* Monica VanSuch, et al., *Effect of Discharge Instructions on Readmission of Hospitalized Patients With Heart Failure: Do All of the Joint Commission on Accreditation of Healthcare Organizations Heart Failure Core Measures Reflect Better Care?*, 15 *QUALITY SAFETY OF HEALTH CARE* 414, 414-17 (2006); Ashish Jha, et al., *Public Reporting of Discharge Planning and Rates of Readmission*, *NEW ENG. J. MED.* 361, 2637-45 (2009).

In one particular study, there was a statistically significant relationship between readmission rates for heart failure and the discharge instructions based on the patient-reported measures from the HCAHPS survey.⁵⁸ This study is particularly relevant to the VBP program because the eighteenth quality measure relies on the HCAHPS survey.⁵⁹ The study postulated that 4,700 fewer readmissions could occur if hospitals could improve their performance on the HCAHPS discharge quality measure to the 90th percentile.⁶⁰ For example, the quality measure could be improved if the patient receives full and complete discharge instructions.⁶¹

In another study, the results showed a statistically significant difference between readmissions for heart failure when patients are given complete versus incomplete discharge instructions.⁶² The study found that heart failure patients that were provided complete discharge instructions were less likely to be readmitted for any cause compared to patients who were only provided minimal instructions.⁶³ Patients who were not provided instructions for activity, drugs, or follow-up appointments were the most likely to be readmitted.⁶⁴ These studies indicate that the inclusion of discharge instructions for heart failure as a quality measure under the VBP program would increase access to health care.

By using a discharge instruction as a quality measure, the VBP program financially incentivizes hospitals to provide patients with discharge information for heart failure.⁶⁵ When patients receive discharge instructions, they are statistically more likely to not be readmitted to the hospital.⁶⁶ Therefore, the VBP program will reduce readmission rates by incentivizing the receipt of instructions. A reduction in readmission rates would, in

58. Ashish, *supra* note 57, at 2637 (The report concludes that there is a “very modest association” between readmission rates and the HCAHPS survey. *Id.* However, the data shows a difference of 2.3 patients with congestive heart failure and 2 patients with pneumonia between the scores on a HCAHPS discharge instruction survey in the lowest quartile and highest quartile. *Id.* at 2644. 2.3 and 2 are statistically significant numbers because the p value is only <.001. *Id.*).

59. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2462.

60. Ashish, *supra* note 57, at 2642.

61. VanSuch, *supra* note 57, at 416.

62. *Id.*

63. *Id.*

64. *Id.*

65. See Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2454, 2457.

66. See Donald Williams, et al., *Emergency Department Discharge Instructions and Patient Literacy: A Problem of Disparity*, 14 AM. J. EMERGENCY MED. 19, 19 (1996).

turn, increase access to health care because less services, beds, and funds would be used to treat those patients whose readmission could have been prevented. Furthermore, it increases potential access to self-care and preventative services because patients will be better informed about their health. This conforms to CMS' effort to transform Medicare into an active purchaser of quality health care and increase access.⁶⁷

IV. ADVERSE EFFECT ON ACCESS

Although Part III discussed potential improvement in access to health care for those patients who utilize the least funds for services, some express concern for those high cost patients.⁶⁸ This Part addresses the specific concern that there could be a fundamental flaw in the application of the definition of value to access with regard to those high cost patients.⁶⁹

In Part I, "value" was described in a literary form. However, "value" can also be defined mathematically as a ratio of quality divided by cost over time.⁷⁰ Therefore, value cannot be determined in cases where a standard for the quality numerator is difficult to determine.⁷¹ Standards of quality are particularly complicated in cases of patients with multiple complex health issues because those patients are most likely to experience errors in care and require quicker treatment.⁷² If the quality numerator in the equation for value cannot be determined, then a value-based purchasing system would be inherently flawed for those patients who need treatment most.⁷³

As previously mentioned, the premise of value-based purchasing is to shift the Current Health Care Spending from those who need treatment most, to the majority of beneficiaries.⁷⁴ The VBP program would be based on a more utilitarian view of access to health care rather than actual need. Therefore, pursuing a reimbursement system that seeks to increase value may decrease access for those patients with costly, multiple

67. Medicare Program: Hospital Inpatient Value-Based Purchasing Program, 76 Fed. Reg. at 2455.

68. See Brent Asplin, *Value-Based Purchasing and Hospital Admissions: Doing the Right Thing Isn't Easy* 56 ANNALS EMERGENCY MED. 258, 259 (2010).

69. See *id.* at 259.

70. *Id.*

71. See *id.*

72. See *id.*

73. See *id.*

74. See discussion *supra* Part III.

complex problems, particularly those who require the most care.⁷⁵ Although the VBP program may adversely affect access for those with multiple complex problems, the underlying issue is the failure to properly treat their condition rather than reimburse for that condition. Instead, PPACA addresses this issue by encouraging the development of new patient care models for the high cost and proper treatment of patients with multiple complex problems.⁷⁶

V. CONCLUSION

Although value and access are often thought of as disparate concepts, the VBP program connects value to actual and potential access. The VBP program will likely increase actual and potential access to health care services for three reasons. First, more funds will be available for more Medicare beneficiaries.⁷⁷ Secondly, beneficiaries will have access to more services because the VBP program incentivizes participating hospitals to provide services that they might not have otherwise provided.⁷⁸ Finally, the use of discharge instructions increases potential access to health care by helping beneficiaries become active participants in their own care.⁷⁹ Still, there are concerns that the VBP program may have a utilitarian perspective on access to health care and decrease access for those with multiple complex problems that desperately need medical attention.⁸⁰ However, multiple complex problems may be better remedied by innovative treatment of the underlying diseases. By valuing the accessibility of services, the VBP program will demonstrate that value can increase access to health care.

75. Asplin, *supra* note 68, at 259.

76. Patient Protection and Affordable Care Act, *supra* note 43, at § 3021. PPACA authorizes the creation of the Center for Medicare and Medicaid Innovation (Center). *Id.* The purpose of the Center is to test new payment and service delivery models including a model for the care of individuals with multiple chronic conditions. *Id.*

77. *See* discussion *supra* Part III.

78. *Id.*

79. *Id.*

80. *See* discussion *supra* Part IV.