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Commentary Open Access

Value-Based Purchasing in Healthcare: How the US Government is Securing Quality Improvement in Care in the United States

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Commentary

Governments have a responsibility to be good stewards of public funds. In the US health care spending accounts for 17.4% of GDP and totalled $2.9 trillion in 2013 [1]. Over the last fifty years the US government has become one of the nation's largest health insurers through sponsorship of programs for elderly and low-income, disabled people. The primary program, Medicare, is run by the Centre for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services. CMS currently funds over a third of the services in the US and insures over 100 million people [2].

On July 1, 1966 Congress authorized the creation of Medicare through title XVIII of the Social Security Act [3]. It covers hospitalizations, along with some outpatient care, and is funded mainly through payroll taxes. Initially, CMS reimbursed hospitals based on self-generated cost reports. This approach provided no incentives for efficiency or quality and CMS struggled with inpatient cost growth which consistently outpaced general inflation and was not associated with improved health outcomes [4].

Historical responses to control spending have been both legislative and regulatory and focused predominantly on hospital reimbursement. In 1983 the agency introduced a prospective payment system for inpatient care which reimbursed hospitals for procedures based on the clinical features of the patient, a system known as diagnoses-related groups (DRG) payment [5]. DRGs also aimed to eliminate the substantial variation in hospital payments across the country for identical procedures.

In the Balanced Budget Act of 1997, Congress phased in a similar reimbursement system for hospital outpatient care, the Outpatient Prospective System (OPPS). It provides bundled payments for outpatient services, based on procedures classified in the Healthcare Common Procedure Coding System, and includes associated ancillary costs, blood tests, and supplies [6]. The effect on spending has been muted by hospitals attempting to maximize reimbursement by shifting from inpatient to outpatient care [7].

Through DRGs, the growth rate of inpatient hospital spending was reduced to that of general inflation [8]. With passage of the Patient Protection and Affordable Care Act (ACA) in 2010, CMS instituted value-based purchasing (VBP). The approach rewards hospitals that meet quality performance targets and fines those that do not, as part of a larger plan to control hospital costs. As such, this new approach formally integrates quality measures into the CMS reimbursement framework [9].

VBP centers on four domains: clinical processes of care; patient care experiences; outcomes and efficiency. Each domain is made of a series of performance measures. For example, patient care experience is rated for: satisfactory communications with nurse, physician and pharmacy-related communications, hospital staff responsiveness, pain management, hospital cleanliness and quietness, provision of discharge information and an overall rating [10].

VBP payments are based on a weighting system across domains. Domain scores reflect achievement relative to the average for all hospitals and improvement compared to the individual hospital's performance in the prior year. Patient care experience is also rated for consistency. The process is transparent to the hospitals as the ranking system is published every year and quality ratings are published on the CMS web-site.

Efforts are incentivized by CMS as the agency withholds a fraction of overall reimbursement to the hospitals. Funds can be earned back as they meet performance targets and those failing to meet targets face a penalty as the monies are not returned if the hospital performs poorly. Hospitals may appeal their ratings. As the program is new and undergoing changes each year, results at this stage are difficult to assess. The number of hospitals receiving bonuses, however, did increase in 2014 compared to 2013 [11].

Over time, CMS has used other methods to increase care quality. One is Medicare Compare, collaboration between CMS and over 4000 health care providers, whereby scores on a range of quality indicators are posted on the CMS website [12]. Medicare Compare is an important effort to inform patient choice. The idea is that patients will be less likely to choice low quality hospitals and the loss in revenue will motivate this group to provide higher quality care.

However, public reporting mechanisms are, in practice, likely to have limited effect on hospital usage as patient hospital choice is highly constrained. Bar emergencies, patients enter hospitals via physician referrals. Physicians, therefore, are the primary decision-makers in terms of hospital selection, although this is clearly done in consultation with the patient. Physician choice, to a large degree, will depend on where he/she has admitting or surgical privileges, has contractual relationships or simply a facility preference. Further, in rural areas, only one hospital may be available.

The importance of the VBP effort should not be minimized as this is the first legislative attempt at a structural change in hospital reimbursement to address quality. Tying reimbursement and quality standards is a sound step in the goal of achieving value and establishing provider accountability. Regulation in this area in particular is warranted, given the vast resources spent on health care and its critical importance to consumers who ultimately fund services through taxation.

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