

Value-Based Purchasing (VBP) of Medical Devices Project

Frequently Asked Questions



Q1: What are the goals and objectives for the VBP project?

A1: IHA's VBP project will provide participants with new information tools and strategies to improve the assessment and purchasing of implants used for major orthopedic, spine, and cardiac procedures.

Specific project deliverables include:

- a. Local and national benchmarks in terms of average cost per implant, total procedure costs, quality metrics, resource use, revenues and margins.
- b. Peer-designed forums to highlight best practices and implementation successes and challenges.
- c. Development of prototype "episode of illness" payment approaches for these technologies, to be tested with one interested health plan and hospital system.

Q2: What benefits accrue to project participants?

A2: IHA's VBP project will help hospitals implement best practice strategies for purchasing high-value, high-volume physician preference items by providing:

1. Reliable, consistently-defined, local and national benchmark data.
2. Opportunities to receive information about promising programs and practices within the context of project forums. For example, IHA will conduct workshops on best practices for technology assessment and managing conflict of interest in purchasing decisions.
3. Corroborating support of IHA—a credible, neutral third party—as you bring new strategies to the table with your internal stakeholders.

Q3: What procedures and devices does the project target?

A3: The project targets 14 DRGs where implant costs account for a high percentage of total reimbursement by Medicare and other payers. About 158,000 patients undergo one of these procedures in California each year. The DRGs are:

- a. Cardiovascular surgery (DRGs 104, 105—cardiac valves with and without cardiac cath); Orthopedic surgery (DRG 544: ICD-9-CM 81.51; 544:81.52; 544:81.54; 545: 81.53 and 81.55—total and partial hip replacement, total knee replacement, hip and knee revisions)
- b. Spine surgery (DRGs 498 and 520—lumbar and cervical spine fusion without CC)
- c. Cardiac rhythm management (DRG 515, 551, 552—defibrillator and pacemaker implants)
- d. Interventional cardiac procedures (DRG 557 and 558—percutaneous cardiovascular procedures with DES, with and without MCV Dx)

Q4: How much work will it be to participate, and what types of resources will be required?

A4: We ask that each health system designate one key coordinator who will ensure all data submission standards and deadlines are met by the health system. This person might be the head of Materials Management or a member of the CFO's direct staff. Less senior staff would typically complete the actual data submission, and answer questions from the data aggregator. Our experience in the demonstration project indicates that these functions represent 25-50 hours of labor. We'll also need staff review of draft benchmark reports to ensure validity and completeness of the data set.

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Q5: What data will we need to provide, and by when?

A5: The data request includes patient demographics, information from your vendor and patient charge records, OR procedures and Implant Log data, and financial information from your Medicare Cost Report and other sources. A copy of the draft data request is available upon request.

We anticipate requesting 2008 data early in 2009.

Q6: Who will you use as the data aggregator?

A6: We have selected Aspen HealthCare Metrics as the data aggregator. Of the potential vendors who submitted bids, Aspen showed the greatest depth of experience with collection of the specific purchasing data relevant to this project. Aspen has developed a strong firewall between its data collection and consulting operations, and those of its parent GPO, MedAssets. Finally, MedAssets has made the strategic decision not to provide group purchasing services for the physician preference items that are at the heart of this project, which should further alleviate the concerns of hospitals who wish to participate in this project while maintaining a group purchasing agreement with another vendor.

Q7: What if I currently have non-disclosure agreements in place with certain device manufacturers?

A7: If you have non-disclosure agreements with device manufacturers, you may wish to provide aggregated, average price information to the project and thus avoid disclosing actual price points for device components. We are in the process of developing a “black box” approach to the collection of price information that will aggregate and mask average charges by vendor so as to ease concerns about non-disclosure.

Q8: Does participation present anti-trust concerns?

A8: The goals of the VBP project are intrinsically pro-competitive—to ensure that health systems and physicians have information and tools that will help them make more informed decisions about the purchase of certain high-value, high-volume medical devices. These tools should in turn allow project participants to increase the quality and value of the health care services they provide to consumers.

IHA has engaged anti-trust counsel, and intends to take care that project data are not used in any anti-competitive way. In particular, the project will not share participant-identifiable price or cost information among participants. The participation agreement also requires participants to keep their project data confidential, and not to share it with their competitors.

Q9: Will our health system performance be disclosed in any form of public reporting?

A9: No. IHA may report the names of participating organizations in our general project materials but will disclose individually identifiable results only to you. Your identity will be masked when sharing comparative results with other participants. No aspect of this project includes the public reporting of any facility or vendor performance. IHA may make aggregated and de-identified data available to academic researchers however, and those researchers may use the data to develop manuscripts for publication. Before providing this information, we would require a consulting contract that ensures confidentiality standards, and requires our approval before resulting papers are submitted for publication.

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Q10: How does the IHA project compare to the services provided by a group purchasing organization (GPO)? Does IHA intend to become or partner with a GPO in the future?

A10: IHA is not and will not become directly involved in actual purchasing decisions or price negotiations. We have no intention to consult with any health system on these issues, or to partner with a GPO to provide these services in the future, as these activities would not be aligned with our mission or tax-exempt purpose.

Q11: What will it cost us? How is the project funded?

A11: There are no direct charges to participants. The project is grant-funded by the Blue Shield of California Foundation (BSCF). BSCF is endowed entirely by Blue Shield of California but has its own Board of Trustees and staff that operate independently of its parent corporation.

Q12: What were the results of the Orange County demonstration project? How does this project build off those results?

A12: The demonstration project showed that it was possible to collect relevant data and create meaningful benchmarks across health systems operating in Southern California. IHA received positive feedback from participants about the value provided by these benchmarks, and favorable evaluations of the statewide IHA-CHA Medical Device Conference held in May 2008. These results and stakeholder support led directly to BSCF's approval of our grant-request to expand the data collection initiative to a state-wide group of participants and to continue to support diffusion of best practices through our planned series of workshops and roundtables. The final report on the Orange County pilot project is available at <http://www.NEED> NEW LINK).