

# From Volume-based to Value-based Payment in Medicare: Some of the Issues

Robert A. Berenson, M.D., F.A.C.P.

Institute Fellow, The Urban Institute

Medicare-Medicaid Payment Summit

30 May 2012

Arlington, VA



# The Presentation Will --

---

Discuss different notions of value-based payment

Explore opportunities for achieving higher value in Medicare – what's in the ACA

Some Medicare opportunities -- and some maybe not so fast



# What Do We Mean By Value?

---

In health policy parlance, Value = Quality/Costs and is used to mean getting a “bigger bang for the buck”

But there is no quantitative precision to the value equation

Is value increased when quality increases at a higher cost? Don't know



# The Quality Numerator

---

Quality is measured differently for each measure, e.g., % compliance with a standard, mortality rate for a condition – there is no common metric, like quality-adjusted life years (QALYS), as used in cost-effectiveness research (but not US health policy)

We have very good quality metrics in some areas with more coming daily. In other important areas, we have few measures, e.g. diagnostic errors, appropriateness of procedures.



# The Cost Denominator

---

Costs are usually measured as dollars spent but can also represent the rate of increase in dollars spent

But even with something as seemingly straight forward as dollars spent, there are disagreements on how to measure and report costs (which go beyond the usual error of mistaking charges or payments for costs).



# There Is Disagreement Over the Role of Measurement in Value-based Payment

---

For some, value-based payment means literally measuring quality and costs and directly rewarding higher measured value. Equivalent to “pay-for-performance.”

For others, it means adopting payment methods that have a higher demonstrated relationship to desired outcomes of care (quality, cost, and patient experience) and using measures more opportunistically -- while relying more on the design of basic payment approaches to affect value



# Some Concerns About Over-Reliance on Measurement

---

Value-based purchasing is a broader concept than pay-for-performance but often the two are equated

Measures and measurement are desirable but have more limitations than often recognized (by policy-makers)

In some areas there are excellent measures. e.g., ESRD. In others, there are major gaps, which may not be filled for the foreseeable future, e.g., diagnosis errors, appropriateness



# The CMS Premier Hospital Quality Improvement Demonstration

---

- Largest P4P program for US hospitals
- Voluntary – 421 hospitals asked, 261 joined
- Ran from late 2003 through 2009
- Rewards performance for AMI, CHF, PN
- Primarily focused on processes, e.g., aspirin and beta blocker use in AMI, antibiotic timing in PN
- Bonus of 1-2% for top 2 deciles
- 2007, changed to reward improvement also





# Jha et al., *NEJM*, Mar 29, 2012

---

Compared 252 hospitals participating in the Premier demo and 3363 control hospitals participating in public reporting

Examined 30-day mortality among > 6 million patients with AMI, CHF, PN or who underwent CABG between 2003 and 2009

Found no evidence of any difference in 30-day mortality nor difference in conditions in which measures included outcomes (AMI, CABG) and those using process measures (CHF, PN)



# Ryan et al., *Health Affairs*, Mar 2012

---

Data from 2000-8. Looked at 30 day mortality for AMI, CHF, and PN, which are conditions in “Hospital Compare” on Medicare website

Mortality has decreased for all three, but improvement did not exceed trend; there was also improvement for conditions not reported

Also, again, improvement on the process measures did not reduce mortality for the reported Dx's.



# Conclusions

---

- The Premier Hospitals P4P demonstration results do not demonstrate proof of effectiveness although performance on quality measures has been improving
- There is increasing doubt that process measures in general predict outcomes, esp. mortality
- Outcome measurement is more difficult but is where the action should be



# Conclusions (cont.)

---

- Mostly untested is whether P4P produces desirable cultural, organizational, and other change which “spillover” into other activities or alternatively “crowd out” other quality enhancing activities
- Regardless, the US seems embarked on a P4P course for hospitals and physicians (and other providers) because the approach sounds appealing to many policy makers (as in education policy) and because it challenges an unacceptable status quo



# When in Doubt, Quote Albert Einstein (If No Yogi Berra Quote)

---

“Not everything that can be counted counts, and not everything that counts can be counted” – Einstein

Value can be increased through approaches other than measures and measurement

We should move more decisively from measuring processes to measuring outcomes, with the attendant operational challenges involved (argument to follow)

Should evolve from measuring at the individual level to the organization as delivery changes



# Affordable Care Act Provisions That Emphasize Measures and Reporting

---

Sec 3001 Hospital Value-based Purchasing starts in 10/12

3007 Physician Fee Schedule Value-based Payment Modifier by 2015 (good luck with this one)

3022 Medicare Shared Savings Program – accountable care organizations (use of performance measures are central to the ACO concept – ACOs don't get to keep money unless they achieve quality targets)



# More ACA Sections Related to Reporting

---

3002 Physician Quality Reporting to provide feedback to physicians on performance – related to meaningful use

3003 Physician Feedback Reports – on resource use

10331 Public Reporting of Physician Performance Information – creates a Physician Compare website by 1/1/13

3015 Collection of Quality and Resource Use Measures



# Many ACA Provisions Do Focus on Incentives and Organization

---

Sec 3021 Center for Medicare and Medicaid Services (\$10 billion dollars already appropriated to test new payment approaches and new organizational models of care, such as accountable care organizations and patient-centered medical homes)

3022 Medicare Shared Savings Program

3023 Bundled Payment Pilot (CMMI moving on 4 models based around a hospitalization. A model for this is the ACES demo (acute care events in southwest hospitals for coronary stents, CABGs, hip and knee replacements.)





# ACA sections (cont.)

---

- 3024 Independence at Home (geriatric home care for frail elderly – to use “shared savings”)
- 3025 Hospital Readmissions Reduction in FY 2012 (is the payment penalty enough to change behavior in hospitals where most needed?)
- 3026 Community-based Care Transitions – already in place to assist hospitals in reducing readmissions
- 3027 Gainsharing Demonstration extension (doesn't gainsharing accomplish the objectives of bundled payments, without the technical and physician-hospital relations difficulties?)



# ACA sections (cont.)

---

3502 Community Health Teams to support PCMH

3506 Shared Decision Making – sets up SHM Resource Centers

3126 Community Health Integrated Model Demo – for tests of rural integration models

3140 Medicare Hospice Concurrent Care Demo

2703 Medicaid Health Home targeted to individuals with chronic conditions

2704 Medicaid Bundled Payment demo in up to 8 states

2705 Medicaid Global Payment System demo for safety net hospitals to move from FFS to global payment in up to 5 states

2706 Medicaid Pediatric ACO demo



# Some Concerns About the Duals “Demonstration”

---

Size and scope suggests this is a waiver program, not a typical demo as envisioned under Innovation Center

- if statewide, makes evaluation problematic
- too big to fail
- hard to say “no” to any other state

Lack of track record in Medicaid managed care with heterogeneous populations of disabled and seniors



# Concerns (cont)

---

Medicare Advantage/SNPs overall don't produce savings. Will plans be allowed to achieve savings through lower payment rates, not improved care?

Quality measures not yet well developed or accepted for particular subgroups

Long list of operational issues that need to be tested, e.g. how passive enrollment with an opt out works



# Need to Clarify the Reasons for Medicare's Expected Huge Impact on the Budget

---

CBO recently estimated that Medicare will grow 1% greater than inflation over next decade, or about the rate of GDP growth (0.7% higher without SGR cuts).

Half of the projected increase in Medicare spending over the next 25 years will be from an increase in beneficiary population served – from <50 million now to 80 million by 2030



# Need to Distinguish Short from Long Term Cost Control Strategies

---

Long term (which I think is at least 8-10 years):

- delivery system and payment reforms
- opportunity for private plans to demonstrate added value, esp. for beneficiaries with chronic conditions
- reform benefit package to decrease need for supplemental insurance and make “value-based”

In the meantime, there are short term opportunities, incl:

- paying smarter
- going after aberrant (often fraudulent) behavior
- CMS having resources to administer its policies



# The SGR Mess Has Obscured Some Basic Problems with the Medicare Fee Schedule

---

Price distortions have led to costly physician behavior, e.g., too much testing

Has contributed to current lack of interest in primary care careers

We now know that one can modify fees to influence desirable physician behavior – see Deficit Reduction Act of 2005 impact on imaging services



# Medicare Physician Fee Schedule

---

Berenson, et al. *What if All Physician Services Were Paid Under the Medicare Fee Schedule? A Contractor Report for MedPAC, 2010*

The study simulated MD compensation as if all of their services (in Relative Value Units) were paid at Medicare Fee Schedule Rates





# Simulation Results

---

For 2007, actual mean M.D. compensation was \$272,000. Simulated at Medicare rates was \$240,000

Some specialties had simulated compensation 2.5X's that of primary care and were in the mid-\$400,000 range

So the assertions that Medicare pays only "80% of physician costs" ignores the generous income take-out that is part of practice costs

And some specialties have no plausible option to not take Medicare patients

Part of reason why MedPAC recommended cuts only to specialists' fees in its SGR proposal



# DME Variation in South Florida

(MedPAC BASF file for 2006)

Counties	Beneficiaries	DME \$ per capita
Collier	60,000	\$220
Monroe	11,000	\$260
Broward	141,000	\$430
Miami-Dade	184,000	\$2200



# Home Health Use, Spending, and Episodes Vary Widely

---

Price adjusted spending per capita in McAllen is more than 7 times national average

In some counties > 35% of beneficiaries use Home Health

MedPAC Sept, 2010

A CMS contractor found that only 9% of claims were properly coded for Houston beneficiaries with the most severe clinical rating served by potentially fraudulent HHAs.

GAO, Feb, 2009



# Hospice Use Patterns Differ Widely

(MedPAC, Sept 2010)

State	decedents in hospice	spending (relative natl. avg.)	Stays > 180 days	Live discharge rate
Miss	35%	1.9	39%	55%
Iowa	48	1.1	16	13
Natl. avg.	39	1.0	18	16



# While Precluded From Considering Costs in Coverage Policies, CMS Can't Really Administer Its Current Policies

---

Some opportunities do not involve use of cost-effectiveness analysis or similar approaches

22.5% of implantable cardio-verter defibrillators don't meet clinical guidelines and, presumably, CMS's coverage policy – at an estimated \$1 billion/yr

In lean times, consider new sources for funding CMS – perhaps a limited draw on mandatory side spending, when purpose is to save \$'s.

