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Future of Value Based Purchasing in a Post-ACA World

By Kevin Malone, Gary W. Herschman and Jackie Selby

I. Introduction

The November 2016 federal elections portend major changes to the role of the federal government in the national effort to reform the U.S. health-care system. Most importantly, the Patient Protection and Affordable Care Act ("ACA") is likely to be substantially repealed. As candidate and as president, Donald Trump has consistently promised to make the repeal of ACA one of his first priorities. His nomination of Representative Tom Price (R-Ga), an intellectual and ideological leader of Congressional repeal efforts, for Secretary of the U.S. Department of Health and Human Services ("HHS") is a further indication that Trump will attempt to repeal the ACA in some form. Members of the 115th Congress have already begun the process of repealing and replacing the ACA now that they have an eager partner in the White House.

This raises the question of whether the process of health-care system transformation, which was accelerated by the ACA, will stop upon its repeal. That is not widely expected. Rather, the trend toward using health-care quality outcomes and cost efficiency as a key basis for the reimbursement for health-care services should continue regardless of the future of the ACA. Commercial insurance companies, large employers, and leading provider systems across the nation have fully embraced this transformation and they will not simply revert to their old systems of health-care delivery and reimbursement. In addition, even if the ACA is repealed, if the Medicare Part A prospective payment systems operate under current regulations and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) regulations are not substantially altered or the underlying statute amended, value-based payment will soon be implemented in some form for nearly all of traditional Medicare expenditures.

However, a repeal of the ACA will nonetheless have a major impact on the federal efforts to implement health-care financing system transformation. The federal Centers for Medicare and Medicaid Services ("CMS") oversees a broad range of initiatives incrementally transforming the Medicare and Medicaid financing system. Many, but not all, of these initiatives are tied to the ACA, so repeal could slow, stop, or completely reverse them. The transformation of the financing system for health-care services in the U.S. is an unfinished project and the federal government will likely play a diminished role in that transformation under the next administration. However, the trend toward paying for value rather than quantity is a train, which has already left the station, that leaders in the commercial market will be driving.

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II. Background on Value-Based Purchasing

Although often conflated with the ACA, health reform is more accurately understood as the process of transformation affecting the coverage, reimbursement,

and delivery of health-care services in the U.S. The goals of this transformation process are commonly understood to be: (1) improved care for individuals, (2) better population health, and (3) lower cost, a trinity referred to as ''the triple aim.''

The most broadly adopted and most important mechanism for attaining these goals is the use of a service provider's performance on health-care quality measures and the cost or efficiency of services as the basis for some or all of the compensation for a given health-care service. This financing method, known as ''value-based-payment'' (''VBP'') is steadily replacing the volume-based mechanism that has previously characterized the health-care system, known as fee-for-service (''FFS''). Actors across the U.S. health-care system have been attempting to implement VBP in earnest in some markets for at least a decade and, although the ACA has been a key catalyst and mechanism for expanding VBP, it is far from the whole story.

Although the Medicare program is traditionally held up as an example of FFS payment, VBP was adopted by Medicare on a large scale before anyone else. In particular, Medicare rolled out the inpatient prospective payment system during 1983-1984 to address the incentive created by the earlier per-diem system for hospitals to keep patients as long as possible. This set the stage for future considerations of VBP.

Beginning in the 1990s, many HMOs and insurers focused on paying providers for reducing costs without simultaneously requiring quality measures be maintained or improved along with achieving such savings. These savings were often achieved simply by reducing utilization or restricting access. This led to arrangements that went bust, providers not getting paid for their services and numerous regulatory changes. These included limitation on the sharing of ''insurance risk'' with providers, at least without regulatory approval and other safeguards like the posting of reserves.

In 2000, the Institute of Medicine (''IOM'') released the first in a series of comprehensive and influential studies of medical errors in the U.S. health-care system. The 2000 report entitled ''To Err is Human: Building a Safer Health System'' found that up to 98,000 people died each year as the result of medical errors and identified the reimbursement structure for health-care services as contributing factor. Through additional studies published from 2000 through 2007, the IOM documented in extraordinary detail the numerous failings of the U.S. health-care system and inability to deliver consistent care of acceptable quality. These reports triggered a major debate about how to improve the quality of the health-care system in general and how to change the compensation of medical providers in particular.

This debate dovetailed with another happening in corporate America; a growing consensus was emerging that employees performed better when their pay was tied to their performance. The recognition that the incentive structure in the health-care financing system was contributing to poor outcomes naturally led to the conclusion that VBP was the solution.

Providers of health-care services, and those that pay for them, have been implementing many more VBP initiatives since 2000 in both public and private markets. For example, in 2001 health plans and provider groups in California began implementing a payment system based on quality measure performance using publicly displayed, uniform quality metrics. Similarly, Medicare tested its first comprehensive VBP initiative in 2005 through the Medicare Physician Group Practice Demonstration, a shared savings program that served as the model for the Accountable Care Organizations (''ACOs'') created by the ACA which have been broadly adopted in both the public and private markets.

It is difficult to draw a conclusion as to the effectiveness of VBP as a whole, both because VBP is a heterogeneous category of initiatives with widely varying characteristics, and because data beyond that from the quality measures used in the payment system itself can be hard to find. However, the meta-analyses that have been performed indicate that VBP has potential to improve quality and save money, especially when implemented in broad partnership with the provider community. For example (among many others):

- Bardach et al., 2013 found that a pay-for-performance experiment resulted in improved performance and outcome measures including reduced blood-pressure compared to control groups.

- Chen et al., 2010 found that a pay-for-performance experiment resulted in significantly greater increases in quality scores for cervical and colorectal cancer screening, HbA1C testing, mammography, and varicella over control groups.

- Chung et al., 2010 found that a bonus pay-for-performance experiment resulted in significant improvement in a broad range of process and outcome measures.

- Leitman et al., 2010 found that a pay-for-performance and shared savings program resulted in $7 million in savings from a single medical center.

There are a multitude of varieties of VBP already in use. In conjunction with Catalyst for Payment Reform's VBP project, the Urban Institute recently proposed a typology of payment methods that goes as far as anyone at organizing and categorizing the wide array of VBP methods in use today. The Urban Institute proposal uses the following factors to organize and categorize payment methods: (a) base vs. incremental payments, (b) the unit of payment, (c) The provider recipient, (d) fixed total vs. activity-based payment, (e) prospective vs. retrospective payment, and (f) other dimensions of a payment. The complexity of the typological approach mirrors the complexity and variety of VBP approaches that are already being implemented in the marketplace. For instance, VBP initiatives can be divided by those that create an intermediate entity between the payer and end-provider that controls some amount of revenue flow. Classic examples are professional corporations but also include the more modern ACO. Other VBP forms include capitated primary care services, prospective payments to hospitals based on diagnosis-related group, global budgets for hospitals, bundled payments based on episodes of care, global capitation, and shared savings, among others. There are a wide range of variations among these as well. No matter what happens with the ACA, this innovation and proliferation of new VBP approaches will continue in the commercial market.

III. VBP in Private Markets

VBP has been broadly adopted in the private market by both commercial insurance payers and employers

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and many of the varieties of VBP listed above have been utilized. According to the Catalyst for Payment Reform's 2014 national scorecard, approximately 40 percent of payments by private plans to health-care providers were based on quality measure performance, rather than the volume of services provided. This represented a major increase in adoption from 2013, when the same scorecard identified that only 11 percent of payments were value-based. These initiatives are being led by both commercial health insurance plans and large employers. They also often involve partnerships between health systems and employers. Importantly, none of these initiatives are dependent upon elements of the ACA and these payers have pursued VBP because they have experienced results through improved quality and cost savings.

IV. The Impact of ACA Repeal and the Future of Medicare/Medicaid VBP

A. Replacements for the ACA. Although the VBP initiatives underway in the private sector are likely to continue apace, regardless of the future of the ACA, there are a number of important VBP initiatives in the publicly funded health benefits programs that could be altered or eliminated if the ACA is repealed.

Republicans in Congress have proposed and even passed a range of alternative programs to the ACA that were not enacted under President Obama's watch. For example, President Obama on Jan. 8, 2016, vetoed H.R. 3762, which was passed without Democratic support through budget reconciliation. The House failed to override the veto. H.R. 3762 would have severely restricted the operations of health insurance exchanges, phased out of funding for subsidies to help lower and middle-income individuals afford insurance, eliminated the individual and employer mandates, and eliminated taxes on medical devices and the most expensive health plans. It also would have phased out the Medicaid expansion over a two-year period. Importantly, H.R. 3762 would not have curtailed the Center for Medicare and Medicaid Innovation, the administrative division within CMS with responsibility and authority for implementing many new VBP initiatives. H.R. 3762 also would not have curtailed the VBP initiatives underway within the Center for Medicare or the Center for Medicaid and CHIP Services, both of which have implemented VBP initiatives through the traditional Medicare and Medicaid programs.

Other potential templates for repeal would have a more significant effect on federally supported VBP. For example, H.R. 2300, the Empowering Patients First Act, was introduced by Tom Price. H.R. 2300 started with a full repeal of the ACA and then would have rebuilt with alternative mechanisms for providing coverage to the Americans currently eligible for coverage through the health insurance exchanges or Medicaid expansion. H.R. 2300 would have limited the authority of the Secretary of HHS to use comparative effectiveness research in coverage or financing policy and would have required any performance-based quality measures used in the Medicare program (for monitoring or payment purposes) to be approved by the applicable physician specialty organizations. H.R. 2300 signaled a strong aversion to payment reform and would have eliminate all of the VBP initiatives created specifically through the ACA.

The final major template for potential repeal is Speaker of the House of Representatives Paul Ryan's plan, entitled ''A Better Way; Our Vision for a Confident America.'' Although it would call for a full repeal of the ACA and does not propose any initiatives to implement VBP in Medicare or Medicaid FFS, the proposal does include an increased use of value-based measurement for the payment of Medicare Advantage Plans as well as provide greater flexibility to plans in the design of their benefits. Speaker Ryan's plan would also include the implementation of a national quality compare website for all Medicare providers. However, the proposal would also prevent HHS from weighting patient experience higher than clinical outcome measures.

B. Potential Impact on CMS VBP Initiatives. In any scenario involving full repeal of the ACA, there will be a curtailment of CMS' activity in implementing VBP. In particular, section 3021 of the ACA created the Center for Medicare and Medicaid Innovation (CMMI), a component of CMS, for the purpose of testing ''innovative payment and service delivery models to reduce program expenditures . . .while preserving or enhancing the quality of care'' for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

Since its formation, CMMI has focused almost exclusively on developing and testing new VBP models for Medicare and helping states develop VBP initiatives in their Medicaid programs. Most of the Medicare VBP models involve creating new VBP mechanisms for providers serving beneficiaries enrolled in traditional Medicare FFS. Prominent demonstration programs include: ACO Models (including six different demonstration models in addition to the Medicare Shared Savings Program itself), the Bundled Payments for Care Improvement initiative (which includes four different levels), the Oncology Care Model, the Comprehensive Primary Care Initiative (with two versions), the Independence at Home Demonstration, and many others. All of these initiatives are testing different approaches to Medicare FFS reimbursement that tie compensation to quality performance in one way or another.

Many of these initiatives have deliberately sought to involve commercial payers as partners to align provider obligations and increase the effectiveness of the programs. For instance, the ACO models allow for participating ACO entities to enter into contracts with private payers subject to less stringent antitrust review. This has led to the coverage of 17.2 million people in commercial market ACOs, a far larger population than the 8.3 in Medicare ACOs. Further, although growth in the Medicare ACO programs has stalled in the past year, growth in commercial market ACO contracts continues to grow rapidly. Similarly, through the Oncology Care Model, CMS has entered into agreements not only with physician practice groups but also with 16 major commercial payers. This integrated approach will ensure that as many payers as possible implement the new bundled payment VBP model. Provider take-up in the Oncology Care Model was nearly twice as high as anticipated. These collaborative efforts and others indicate how CMMI's VBP initiatives serve as a catalyst for commercial payer VBP.

All of these CMMI initiatives will stop if the ACA is fully repealed. However, absent substantial concurrent reform to the traditional Medicare and Medicaid pro-

grams themselves, a great deal of the volume of Medicare and Medicaid VBP activity may continue unabated. Although CMMI is a leading catalyst for VBP models and promulgates a great variety of initiatives, the Medicare and Medicaid programs themselves have also steadily been incorporating VBP into their general operations. For example, the Medicare Physician Fee-Schedule, long held up as an archetypal FFS boondoggle, has recently implemented a modifier to physician payments where physicians receive a different level of payment based on their performance on quality measures. Similarly, the Medicare Part A benefit programs have expanded the prospective payment system from inpatient hospitals into the other benefit categories (inpatient rehabilitation facilities, skilled nursing facility care, long-term acute care hospitals, hospice, and home health). Medicare has taken steps in recent years to increase the variation among payments in these systems based on quality.

Medicaid has even more flexibility to implement VBP outside the ACA. Although the inflexibility of the Medicaid program is much lamented, CMS does oversee numerous waiver and demonstration authorities that allow states the flexibility to pilot alternative payment mechanisms. Further, through the proliferation of Medicaid managed care delivery systems, commercial insurance companies operationalize much of the Medicaid program and are encouraged through CMS regulations to engage in VBP contracts with participating providers.

The Trump administration could halt or reverse this trend of greater VBP implementation in traditional Medicare and Medicaid. Tom Price, in addition to serving as a leading ACA repeal advocate, has been an outspoken critic of mandatory VBP programs in Medicare and the rapid growth of measure-reporting-based quality improvement programs in general. Price took particular issue with the Comprehensive Care for Joint Replacement (CJR) model. The CJR model is a mandatory variant of the CMMI bundled payment initiatives that began on April 1, 2016, and holds hospitals accountable for the quality of care they deliver to Medicare FFS beneficiaries for hip and knee replacements and/or other major leg procedures from surgery through recovery. Congressman Price has opposed mandatory VBP demonstrations and his proposed ACA replacement legislation indicates a preference for greater deference to physician discretion in all aspects of health care. Although it is unclear that he has any intention to halt or reverse the trend toward VBP in the traditional Medicare and Medicaid programs (other than by repealing the ACA itself), it is likely that he will slow the process and defer to medical specialty organizations rather than payers, researchers, or consumer advocates in the identification of quality and cost metrics used in VBP initiatives.

C. ACA Repeal and MACRA. Equally important as the role of the ACA on the promulgation of VBP initiatives is MACRA. MACRA replaced Medicare's Sustainable Growth Rate formula to pay for physicians' and other providers' services under Medicare Part B and builds upon the VBP initiatives created by CMS under the ACA. MACRA created a new comprehensive VBP program for all of Medicare Part B services called the Quality Payment Program (small practices are exempt). The MACRA Quality Payment Program has 2 tracks covered providers can choose from: (1) The Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (APMs).

Providers could begin participating in Track 1 as early as Jan. 1, 2017, but no later than October 2, 2017 with a requirement to submit performance data by March 31, 2018 at the latest. Providers that submit a full year of 2017 quality data are eligible for a positive payment adjustment based on the quality of care delivered. Providers that fail to submit any data will be subject to a draconian negative four percent adjustment to their payment rates.

Track 2 is only available for providers that receive a substantial portion of their revenue from participation in ''Advanced APMs.'' Advanced APMs must meet rigorous requirements including that the provider must take on ''more than nominal financial risk for losses'' or participate in certain CMMI demonstration models. Providers who successfully participate in Track 2 are eligible for even larger positive incentive payments than those in Track 1 (that grow over time) and are exempt from the Track 1 MIPS reporting requirements (and downward payment adjustments).

Both tracks meet the broad definition applied here for VBP, meaning that by the end of 2017, absent regulatory changes by the new administration or congressional action, all of Medicare Part B services except for those delivered by small providers will be through VBP of some sort. As such, even if the ACA is repealed, if MACRA regulations are not substantially altered or the underlying statute amended, VBP is coming to all of Medicare.

However, a full repeal of the ACA will slow the implementation of MACRA and has the potential to substantially increase the number of providers stuck in Track 1. The track-based system and tiered payment adjustments indicate that a key goal of MACRA is moving as many Medicare providers as possible up to Track 2 Advanced APMs over time. CMMI plays a critical role in implementing the Advanced APM elements of the Quality Payment Program. In particular, MACRA gives preferential treatment to Advanced APMs created by CMMI and CMS has already begun to make changes to other CMMI models to allow participants to qualify as Advanced APMs under MACRA. As such, a full repeal of the ACA that eliminates CMMI and the Advanced APMs operated by CMMI will force many more Medicare providers into Track 1 and slow or halt any progress up to the increased payments, savings, and quality performance envisioned by Track 2.

V. Conclusion

Although a full repeal of the ACA would likely result in a slowing of the implementation of VBP in Medicare and Medicaid, the trend toward greater adoption of VBP will likely continue unabated. Due to the long history of VBP innovation in the private sector and rapid acceleration in its adoption, payers and providers will continue to pursue more opportunities for VBP. In addition, absent major changes by the Trump administration, due to trends in federal health-care financing beyond the ACA, including MACRA especially, VBP will continue to be a major factor in the Medicare and Medicaid programs. The ACA has served as a major catalyst for payment reform, starting an irreversible process toward VBP that will live on even if, or after, it is repealed.

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