HHS Declares Value-Based Purchasing Goals: Implications for the Health Care Industry

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1. What’s New?

On January 26, 2015, Secretary of Health and Human Services (HHS) Sylvia M. Burwell announced time-specific quantitative goals for Medicare to pay providers based on “quality, rather than the quantity of care they give patients.”1 The announcement presented no new payment concepts, but it did articulate definitive goals as to the percentage of Medicare fee-for-service payments that will be made under value-based models such as accountable care organizations (ACOs) and bundled payments.

In 2014, Medicare fee-for-service payments totaled $362 billion or about 12 percent of all U.S. national health expenditures. With that much weight held by one payer, the Secretary is betting that, as Medicare goes, so will go much of the health care industry.

Indeed, in coordination with the HHS announcement, a newly formed coalition comprised of 20 health systems and payers and calling itself the Health Care Transformation Task Force released a vision to change payment to “incentivize and hold providers accountable for the total cost, patient experience and quality of care for a population of patients, either across an entire population over the course of a year or during a defined episode that spans multiple sites of care.”2 One shared aim of HHS and the private sector groups is to adopt uniform models and metrics so as to minimize the burden on providers as new payment models are deployed.

These initiatives reflect a belief held in common among health care industry leaders that, until payment innovations are adopted broadly and forcefully, providers will continue to be driven by the volume-related incentives implied by fee-for-service payment – or, at minimum, conflicted. This is unsustainable.

2. Definitions and Goals for Value-Based Payment

In an earlier (May 2014) publication, HHS outlined a framework of four categories of payment:3

1. Fee-for-service with no link to quality: the traditional Medicare payment model now out of favor.

2. Fee-for-service with a link to quality and efficiency: physician value-based modifier; hospital

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penalties for excess readmissions and hospital-acquired conditions.

3. Alternative payment models based on fee-for-service architecture, with some payment linked to effective management of a population or an episode of care, for example, ACOs, bundled payments, Medicare-Medicaid financial alignment initiative.

4. Population-based payment wherein payment is not directly triggered by service delivery but instead providers are paid for a beneficiary for a period of a year or longer, for example, the Pioneer ACO payment model after those ACOs have operated 3-5 years.

In the announcement, Secretary Burwell set a 2016 goal that 85 percent of Medicare Part A and Part B payments will be in categories 2 to 4 and 30 percent of payments will be in categories 3 and 4. By 2018, these percentages are targeted to rise to 90 percent and 50 percent, respectively.4 The goals imply that category 2 will constitute 55 percent of payments in 2016, then drop to 40 percent in 2018 as categories 3 and 4 together rise to 50 percent.

The focus on Part A and Part B reflects the fact that Medicare Part C (Medicare Advantage) and Part D (the prescription drug benefit) entail contracting on a fixed prepaid basis with private plans. To the extent fee-for-service payment exists in those parts of Medicare, such transactions constitute a matter between the private plans and their participating providers.

3. Focus of CMS Value-Based Purchasing Programs

CMS’s strongest ambitions during the 2015-2018 window appear to focus on category 3, models that seek to enhance the value delivered for populations over spans of time or for episodes of care.

Category 2 measures amount to patches for weaknesses in the current system – such as by penalizing hospitals for excess readmissions – but they do not change the fundamentals of fee-for-service payment. Category 4 measures approach capitation payment and, while seen as a desirable way to restructure incentives, are not scalable in the near term.

The two predominant models in category 3 are ACOs, manifested in the Medicare Shared Savings Program (MSSP), and bundled payments, being rolled out via the CMS Innovation Center’s program known as Bundled Payments for Care Improvement (BPCI).

a. Medicare Shared Savings Program

In MSSP, the base payment formulation remains fee-for-service: Medicare beneficiaries are free to use any providers and the Medicare program pays those providers the usual rates. However, providers that organize into ACOs and enter into MSSP contracts with CMS are eligible for rewards if they both lower the total cost of care for attributed beneficiaries and score favorably on a set of 33 quality measures. ACOs that volunteer to share in losses as well – referred to as two-sided risk sharing, or Track 2 – are eligible to receive a higher share of any gains realized: 60 percent instead of 50 percent. To date, 98 percent of ACOs have opted for gain-sharing only.

MSSP has seen mixed success. CMS released these results of MSSP’s first performance year in September 2014:5

- 58 of 220 MSSP ACOs held spending $705 million below their targets and earned performance payments of $315 million. Total net savings to Medicare is about $383 million in shared savings, including repayment of losses for one Track 2 ACO.
- 60 additional ACOs reduced health costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- MSSP ACOs improved on 30 of 33 quality measures. Quality improvement was shown in such measures as patients’ ratings of providers and various preventive care activities.

CMS reports that 89 ACOs were added to MSSP effective January 2015, giving MSSP a total of 405 participating ACOs serving an estimated 7.2 million beneficiaries.7

CMS intended to phase out the gain-sharing-only option at the end of each ACO’s first three years of performance. A groundswell of resistance from ACOs and provider advocates has led CMS to change course. In December 2014, CMS issued a draft revised rule governing the operation of MSSP, in which the agency proposed to extend Track 1, the gain-sharing-only option, for another three years, subject to some modified conditions.8 ACOs could stay on Track 1 during their second three-year agreement period if they reached quality targets in at least one 12-month performance period and did not show Medicare losses above a set point. To spur ACOs to move to Track 2, CMS proposed to cut the Track 1 gain-sharing rate from 50 percent to 40 percent. CMS also introduced a new Track 3 for ACOs eager to take on two-sided risk: ACOs can share up to 75 percent of gains in exchange for accepting risk for 75 percent of losses.

Relating this back to Secretary Burwell’s announced goals for value-based payment, it is evident that HHS is searching for a balance. To maximize provider participation in value-based payment programs, the Department appears willing to ease back on its ACO risk-reward ambitions and to make other provider-friendly


6 CMS, “Medicare Shared Savings Program Performance Year 1 Results, 9/2014” http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-PY1-Final-PerformanceACO.pdf


adjustments such as informing ACOs earlier about the beneficiaries that are attributed to them.

b. Bundled Payments for Care Improvement

In general, a bundled payment is understood to be a predetermined fee for all services required by a patient from a measurable beginning of an episode of care until a measurable end of that episode. The payer remits this fee to a designated agent of the providers involved in the patient’s care during the episode, then the agent distributes portions of the bundled fee to each participating provider according to their internal agreement.

Bundled payments are not new in Medicare, though the design has evolved. The Health Care Financing Administration (HCFA, the earlier name of CMS) ran the Medicare Participating Heart Bypass Center Demonstration from 1991 to 1996, testing the feasibility of paying bundled fees to hospitals and physicians for coronary artery bypass graft (CABG) surgeries.9 Four hospitals were chosen initially; three more joined later. They bid global prices that encompassed all hospital inpatient costs – including costs of any 30-day readmissions – and physician fees.

The bundled CABG fee was supposed to represent a discount from what Medicare would otherwise pay, and indeed HCFA reported savings on the cases run through the demonstration. The participating hospitals had mixed experience in terms of net margin and physician alignment with the incentives. There was also confusion among physicians about where to send claims.

HCFA later in the 1990s tried broadening the bundled pricing concept under a “Centers of Excellence” moniker, adopted to help the hospitals attract more patients through the demonstration. The participating hospitals had mixed experience in terms of net margin and physician alignment with the incentives. There was also confusion among physicians about where to send claims.

BPCI includes four models, the fourth being very similar to the global inpatient fee tested in the CABG and ACE demonstrations and the only one in which Medicare pays the provider entity just the one lump sum fee. Model 1 encompasses virtually all types of cases. In models 2-4, participating providers may select from a menu of 48 care episodes.12

- Model 1: The episode is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a rate representing a discount from the rate set under the Inpatient Prospective Payment System. Medicare continues to pay physicians separately for their services, using the Medicare Physician Fee Schedule. Only Part A services are included in the bundle, though under certain conditions, hospitals may share with physicians the savings produced by their care redesign efforts.

- Model 2: Encompasses the Model 1 episode and payment style and adds post-acute care for up to 30, 60 or 90 days. Both Part A and Part B services are included in the bundle, though under certain conditions, hospitals may share with physicians the savings produced by their care redesign efforts.

- Model 3: Covers Part A and Part B services in post-acute care (PAC) only. The episode begins at initiation of PAC services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The PAC services included in the episode must begin within 30 days of acute hospital discharge and end a minimum of 30, 60, or 90 days after the start of the episode.

- Model 4: Medicare pays a prospectively determined lump sum payment to the hospital that encompasses all Part A and Part B services rendered during the inpatient stay by the hospital, physicians, and other practitioners. The practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled fee. Related readmissions for 30 days after hospital discharge are included in the bundled fee.

BPCI was launched in early 2013 with 450 participating providers entering a testing phase that entails no risk, though that number dropped to 342 in January 2014. CMS solicited more participants, raising the number to approximately 6,000 by July 2014, though only 243 providers were actually subject to bundled payments at that time. A very small fraction of the 6,000 participants – 32 hospitals – chose models 1 or 4. Model 3 gained some 4,000 participants and Model 2 attracted 2,000.13

Perhaps the high participation in Model 3 is a reflection of interest on the part of post-acute care providers to enter the arena of value-based payment, since they have no opportunity to lead ACOs. Though time will tell if the providers stay engaged once they actually experience the bundled payments.

A new initiative under the BPCI banner, announced by CMS on February 12, 2015, is the Oncology Care Model, in which oncology practices “will enter into payment arrangements that include financial and perfor-

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mance accountability for episodes of care surrounding chemotherapy administration to cancer patients.\(^{14}\) Payment takes two forms: the first is a $160 fee per beneficiary per month to support the practice’s efforts in coordinating patient care; the second is a potential reward for lowering the total cost of care while improving patients’ treatment.

4. HHS Authority to Implement Changes

Secretary Burwell’s January 2015 announcement is not substantively different from the many previous calls made by government leaders and private sector health care purchasers to shift payment to reward value over volume. What is different is that the Secretary laid down quantitative goals for Medicare – the single most influential payer in the U.S. – to drive the preponderance of business in its fee-for-service components toward value-based models.

Not included in the announcement is evidence of new powers that HHS/CMS has obtained, or will seek, to reach the stated goals. Rather, beyond the bully pulpit nature of the announcement, it appears that CMS will use its regulation writing authority and its demonstration authority to draw more providers into existing and new variants of value-based payment.

Most noteworthy, perhaps, is CMS’s decision to extend the gain-sharing-only option for ACOs another three years. Had CMS held firm to the original policy, it is very likely that the Medicare Shared Savings Program would stall, if not suffer a serious reversal.

Yet even this policy shift has not fully satisfied the provider community. For example, the American Hospital Association’s letter to CMS commenting on the proposed rule stated, “AHA urges CMS to modify the shared savings determination so that more ACOs can share in more of the savings they generate. This will allow them to continue to invest in the program and give ACOs adequate tools to coordinate and manage care.”\(^{15}\)

5. Implications for the Health Care Industry

Medicare and other health care purchasers will continue to nudge more in the direction of value-based pay-ment. They will do this by delegating increasing shares of the risk and reward for costs – and sometimes for quality – either to the providers actually rendering care or to aggregators of providers.

For health care providers, important questions must be answered. Here are three:

First, will a large share of health care purchasing switch over to new models in the near term, as Secretary Burwell professes? There are those that harbor doubts, sensing that this movement is an echo of the 1990s when Clinton-era reform plans spurred providers to establish risk-bearing capabilities and enterprises, only to see the momentum fizzle. This time may be different, though. Public purchasers have become less able to pass cost increases on to taxpayers. Private payers face headwinds in the broader economy and specific obstacles such as the so-called “Cadillac tax” on high cost health plans looming in 2018.

Second, if providers choose to oppose the change, could they succeed? The answer here will be market-specific and provider-specific. Thanks to consolidations and the narrowing of supply in some niches, in many communities there are providers who face little competition and who can, in effect, set their own terms. Providers in such positions today cannot expect to stay secure in the long run, however. With regulatory enforcement of anti-competitive behavior and the potential for disruptive innovation – the proliferation of remote health technology and retail clinics being just two examples – payers may gain alternatives.

Third, to the extent payment does shift markedly, will the opportunity for reward be sufficient to allow providers make the necessary investments? Examples include new technologies to aid population health management, new care management personnel, new workflows and other vital cultural adaptations, and new incentive arrangements to compensate practitioners who contribute to producing savings. The answer here depends in part on the payers themselves. They must design compensation formulas fairly and they must resist the temptation to lower payment amounts too swiftly as providers deliver efficiencies.

So, change will happen. Successful providers will be those that over the next few years can do a good balancing act having one foot in each of two canoes. They must optimize fee-for-service while being responsive to value-based purchasing where it arises. And they must prepare for the day when the tipping point arrives and the predominant mode of payment is value-based.

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\(^{14}\) CMS Innovation Center, Oncology Care Model, http://innovation.cms.gov/initiatives/Oncology-Care/