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Value-Based Reimbursement: Be Careful What You Wish For – Number of Quality Programs Expands Post- ACA (Part Two of a Three-Part Series)

In March 2010, Congress directed the Secretary of the *United States Department of Health and Human Services* (HHS) to *"…establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health"* in § 3011 of the *Patient Protection and Affordable Care Act* (ACA).[1] Comparatively, nearly a decade before the passage of the ACA, Congress directed the Secretary of HHS to *"…expand the use of incentives… that encourage coordination of the care furnished to individuals… encourage investment in administrative structures and processes to ensure efficient service delivery; and reward physicians for improving health outcomes"* in § 412 of the *Consolidated Appropriations Act, 2001*.[2] There are two key differences between these congressional mandates to the Secretary of HHS:

(1) § 3011 of the ACA does not include the caveat that the use of incentives to encourage improvements in the provision of healthcare (i.e., value-based reimbursement models) need to be tested as a general strategy, unlike § 412 of the *Consolidated Appropriations Act, 2001*; and,

(2) While both of these directives call for improvements to both healthcare delivery and outcomes, the text of the ACA specifically includes a focus on *population health*.[3]

This Health Capital Topics article is the second installment in a three-part series examining the evolution of value-based reimbursement in the United States. This second article will examine the impact of the ACA and activities of the *Centers for Medicare & Medicaid Services* (CMS) on value-based reimbursement in the United States.

As discussed in Part 1 of this series "*Value-Based Reimbursement: The First Steps*," throughout the 1990s and 2000s, CMS conducted small scale demonstration projects, followed by broader programs, to test and implement *pay-for-reporting* (P4R) and *pay-for-performance* (P4P) programs. As a brief review: (1) P4R programs are characterized by their utilization of financial incentives for providers that report data on certain pre-defined metrics,[4] allowing individuals with access to that information to make informed decisions about their healthcare;[5] and, (2) P4P programs are payment models that are characterized by their utilization of financial incentives that are *directly* tied to measures of the quality or efficiency of care provided.[6] In the 2010s, CMS continued this experimentation with various formats of value-based reimbursement, guided by the *national strategy* established in § 3011 of the ACA.

In the years following the 2010 passage of the ACA, HHS has proposed, tested, and implemented a number of value-based reimbursement programs.[7] In § 3021, the ACA specifically establishes the *Center for Medicare and Medicaid Innovation*, an agency within CMS with the specific purpose of "*… test*[ing] *innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care furnished to individuals….*"[8] To date, the *Center for Medicare and Medicaid Innovation* has proposed or implemented over 60 programs.[9] It should be noted that, as discussed in Part 1 of this series, value-based reimbursement programs are often limited to a specific set of providers. By implementing a large number of value-based reimbursement initiatives, CMS may be able to expand value-based purchasing to a wider variety of providers and settings in the healthcare industry.[10]

Notably, a qualitative analysis conducted in 2014 by the *Research and Development* (RAND) Corporation found that the more recent P4P programs are typically more complex than their earlier counterparts, involving more metrics of quality and resource utilization, and employing a wider range of financial incentives.[11] For example, the *Premier Hospital Quality Incentive Demonstration Project* (HQID), a pre-ACA demonstration intended to test P4P in a hospital setting, originally utilized 33 quality metrics.[12] Comparatively, the *Hospital Value-Based Purchasing Program*, a P4P program initiated by the ACA that also targets hospitals,[13] utilizes the *Hospital Inpatient Quality Reporting Program* for its quality component,[14] which includes 64 measures.[15] Similarly, the *Medicare Physician Group Practice Demonstration* (PGP), a pre-ACA demonstration intended to test P4P in physician practices, utilized only 32 quality metrics,[16] while the *Physician Value-Based Payment Modifier*, an ACA P4P initiative that targets physician practices,[17] utilizes the *Physician Quality Reporting System* quality component,[18] which includes nearly 300 quality

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metrics,[19] of which individual practices must report data on at least ten.[20] This expansion of the number and scope of value-based reimbursement programs following the passage of the ACA is in keeping with the ACA's *national strategy*; most notably the fourth priority established by the ACA, i.e., to "*…improve Federal payment policy to emphasize quality and efficiency…*"[21]

In addition to the ACA's expansion of the programs described above, the ACA also introduced a new model of value-based reimbursement to the U.S. healthcare industry, in the form of *shared savings*. While shared savings is not a new methodology, having been introduced in the PGP demonstration,[22] the ACA's introduction of *accountable care organizations* (ACOs),[23] organizations in which a set of providers are held accountable for the cost and quality of care delivered to a specific population of a payor's beneficiaries, under a contract with that payor,[24] expanded the utilization of shared savings as a model for healthcare reimbursement in the United States. ACOs are similar to P4P initiatives in that, in order to reap shared savings payments, providers must meet certain thresholds on various quality metrics (currently, 33 quality metrics).[25] Additionally, like P4P initiatives, ACOs must restrain healthcare spending in order to earn the shared savings payment, although under the shared savings model, these rewards are calculated as a portion of the savings that ACOs generate, rather than a pre-defined incentive payment.[26] After their introduction in the ACA, the number of ACOs ballooned, increasing from less than 100 in the second quarter of 2011, to nearly 800 by the end of 2015.[27] Despite the apparent popularity of ACOs, indicated by the rapid growth of these emerging healthcare organizations, many ACOs have had difficulty generating shared savings; out of the 333 ACOs that contracted with Medicare under the *Medicare Shared Savings Program* (MSSP) for performance year 2014, only 92 ACOs (27.6%) generated shared savings payments.[28]

ACOs are differentiated from standard P4P initiatives in two key areas. First, the ACO model specifically calls for multiple types of practitioners in various settings to work together, providing coordinated care to their patients.[29] This distinguishes ACOs from P4P and P4R programs, which often target a specific category of providers, as discussed in Part 1 of this series.[30] Second, as the acronym suggests, ACOs are *accountable* for a defined population of beneficiaries.[31] Under the MSSP, Medicare beneficiaries are assigned to ACOs based on the practitioners who provide the plurality of the beneficiaries' primary care services.[32] However, the ACOs' costs (and, therefore, shared savings payments) are calculated based on *all* Medicare expenditures for these beneficiaries.[33] Therefore, in order to reap financial rewards (or avoid penalties), ACOs must: (1) provide high quality care (as per the 33 quality metrics); and, (2) restrain Medicare spending, not only for the patients that they treat, but for the entirety of the population for which they are responsible. These requirements serve to realize the ACA's *national strategy*, which specifically includes a focus on population health.[34]

In keeping with the congressional directives in the *Consolidated Appropriations Act of 2001* and the ACA, and in an attempt to reform and improve the United States healthcare system, the federal government has pursued various value-based reimbursement models, at first experimenting with P4R initiatives, then shifting to P4P programs, and, more recently, utilizing shared savings models.[35] It should be noted that many of these value-based reimbursement initiatives contain an explicit focus on improving the cost and/or quality of healthcare services,[36] both of which are included in the ACA's *national strategy* on healthcare.[37] However, these initiatives often do not emphasize *access* to healthcare,[38] which is also included as a priority in the ACA's *national strategy*,[39] which strategy echos, in part, William Kissick's *iron triangle of healthcare*, i.e., the inherent tension in attempting to simultaneously improve upon: (1) cost; (2) quality; and, (3) access.[40] However, it should be noted that the federal government may pursue improvements in access to care through other means outside of value-based purchasing models.

The recent efforts toward value-based reimbursement models have arguably had a positive impact on the quality of healthcare services rendered in the United States. According to the *Agency for Healthcare Research and Quality*'s (AHRQ's) *2014 National Healthcare Quality and Disparities Report*, the quality of healthcare services in the United States has measurably improved over the last several years.[41] For example, between 2010 and 2013, the rate of hospital-acquired conditions fell by 17%, resulting in an estimated 1.3 million fewer incidents of patient harm, 50,000 lives saved, and $12 billion in cost savings.[42] Notwithstanding those apparent advances, the AHRQ reported that, *"[p]erformance on many measures of quality remains far from optimal … On average, across a broad range of measures, recommended care is delivered only 70% of the time."*[43] In a 2014 report by *The Commonwealth Fund*, the quality of healthcare delivered in the United States compared moderately well to other developed countries, ranking fifth out of 11 industrialized nations in overall quality of care.[44] The impact of value-based reimbursement on the cost of healthcare services in the United States has been similarly mixed. While the annual growth in national health expenditures dropped dramatically between 2002 (9.6%) and 2013 (3.6%),[45] the share of Americans without a usual source of care due to health insurance or their financial status grew over the same period, from approximately 15% to approximately 20%.[46] In regards to the efficiency of healthcare services, the same 2014 *Commonwealth Fund* report ranked the United States eleventh out of eleven developed nations.[47] These results indicate that while the quality and efficiency of healthcare services in the United States has improved as value-based reimbursement programs have been pursued, there are still significant gains to be made.

The third and final installment of this series will examine some of the most recent developments in

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value-based purchasing, explore their potential impacts for the future of healthcare reimbursement in the United States, and evaluate the overall effect that value-based reimbursement has had on the United States healthcare system over the past two decades.

1 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, § 3011, 124 Stat. 119, 378 (March 23, 2010).
2 "Consolidated Appropriations Act, 2001" Pub. L. No. 106-554, § 412, 114 Stat. 2763, 2763A-509 (December 21, 2000).
3 Patient Protection and Affordable Care Act, March 23, 2010, § 399HH (a) (1).
4 "Pay for Reporting: Quality Assessments Only Methodology" By Eugene J. Nuccio, PhD, University of Colorado Denver, Division of Health Care Policy and Research, July 2, 2014, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Pay-for-Reporting-Quality-Assessments-Only-Methodology.pdf (Accessed 2/26/2016), p. 1.
5 "Hospital Inpatient Quality Reporting Program" Centers for Medicare & Medicaid Services, September 13, 2013, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html (Accessed 2/25/2016).
6 "Pay-for-Performance in Health Care" By Jim Hahn, Congressional Research Service, December 12, 2006, http://www.allhealth.org/briefingmaterials/crsreportingforcongress-pay-for-performanceinhealthcare-501.pdf (Accessed 2/26/2016), p. 2.
7 "Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions" By Cheryl L. Damberg et al., The RAND Corporation, 2014, http://www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR306/RAND_RR306.pdf (Accessed 2/24/2016), p. 1-2.
8 Patient Protection and Affordable Care Act, March 23, 2010, § 3021.
9 "Innovation Models" Centers for Medicare & Medicaid Services, https://innovation.cms.gov/initiatives/index.html#views=models (Accessed 3/7/2016).
10 Cheryl L. Damberg et al., 2014, p. 1- 2.
11 *Ibid*, p. 1.
12 Additional quality metrics were later added to the demonstration; "CMS/Premier Hospital Quality Demonstration Project: Measure Comparison" Centers for Medicare & Medicaid Services, 2010, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierClinicalConditionsMeasuresAndListOfRevised.zip (Accessed 3/8/2016).
13 Patient Protection and Affordable Care Act, March 23, 2010, § 3001.
14 "Hospital Value-Based Purchasing" Centers for Medicare & Medicaid Services, October 30, 2015, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/ (Accessed 3/8/2016).
15 "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals; Final Rule" Federal Register Vol. 80, No. 158 (August 17, 2015), p. 49325, 49649.
16 "Medicare Physician Group Practice Demonstration: Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration" Centers for Medicare & Medicaid Services, July 2011, https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/pgp_fact_sheet.pdf (Accessed 2/25/2016), p. 1.
17 Patient Protection and Affordable Care Act, March 23, 2010, § 3007.
18 "Value-Based Payment Modifier" Centers for Medicare & Medicaid Services, March 4, 2016, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html (Accessed 3/8/2016).
19 "PQRS_2016_Measure_List_01072016" Centers for Medicare & Medicaid Services, 2016, http://www.cms.gov/apps/ama/license.asp?file=/PQRS/Downloads/PQRS_2016_Measure_List_01072016.xlsx (Accessed 3/8/2016).
20 "How to Get Started: 2016 PQRS" Centers for Medicare & Medicaid Services, March 3, 2016, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html (Accessed 3/8/2016).
21 Patient Protection and Affordable Care Act, March 23, 2010, § 3022.
22 CMS, July 2011.
23 Patient Protection and Affordable Care Act, March 23, 2010, § 3011.
24 "Health Care Reform Requires Accountable Care Systems" By Stephen Shortell and Lawrence Casalino, Journal of the American Medical Association, Vol. 300, No. 1 (July 2, 2008), p. 95; "The Adviser's Guide to Health Care: Volume I: An Era of Reform – The Four Pillars" By Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, and Todd Zigrang, MBA, MHA, RACHE, ASA, New York, NY: American Institute of Certified Public Accountants, 2015, p. 133.
25 "Medicare Shared Savings Program Quality Measure Benchmarks for the 2015 Reporting Year" Centers for Medicare & Medicaid Services, February 2015, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2015.pdf (Accessed 6/30/2015), p. 1.
26 "Methodology for Determining Shared Savings and Losses Under the Medicare Shared Savings Program" Centers for Medicare & Medicaid Services, April 2014, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf (Accessed 2/24/2015), p. 2.
27 "Projected Growth of Accountable Care Organizations" By David Muhlestein et al., Leavitt Partners, December 2015, http://leavittpartners.com/wp-content/uploads/2015/12/ACO-Projections-12.22.2015.pdf (Accessed 3/8/2016), p. 1.
28 "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014" Centers for Medicare & Medicaid Services, August 25, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html (Accessed 3/8/2016).
29 "Health Care Reform Requires Accountable Care Systems" By Stephen Shortell, et al., Journal of the American Medical Association, Vol. 300, No. 1 (July 2, 2008), p. 95; "The Adviser's Guide to Health Care: Volume I: An Era of Reform – The Four Pillars" By Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, and Todd Zigrang, MBA, MHA, RACHE, ASA, New York, NY: American Institute of Certified Public Accountants, 2015, p. 133.
30 *See*, "The Reimbursement Environment for Telemedicine Services" Health Capital Topics, Vol. 9, Iss. 2, (February 2016).
31 "The Adviser's Guide to Health Care: Volume I: An Era of Reform – The Four Pillars" By Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, and Todd Zigrang, MBA, MHA, RACHE, ASA, New York, NY: American Institute of Certified Public Accountants, 2015, p. 133.
32 "Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology" Centers for Medicare & Medicaid Services, December 2015, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V4.pdf (Accessed 3/8/2016), p. 15-19.
33 *Ibid.*
34 Patient Protection and Affordable Care Act, March 23, 2010, § 3011.

(Continued on next page)

35 Cheryl L. Damberg et al., 2014, p. 2-3.
36 *Ibid*, p. 14.
37 Patient Protection and Affordable Care Act, March 23, 2010, § 3011.
38 Cheryl L. Damberg et al., 2014.
39 Patient Protection and Affordable Care Act, March 23, 2010, § 3011.
40 "Medicine's Dilemmas: Infinite Needs Versus Finite Resources" By William L. Kissick, MD, DrPH, New Haven, CT: Yale University Press, 1994, p. 2-3.
41 "2014 National Healthcare Quality and Disparities Report: Chartbook on Care Affordability" Agency for Healthcare Research and Quality, United States Department of Health and Human Services, June 2015, http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2014chartbooks/patientsafety/2014nhqdr-ptsafety.pdf (Accessed 3/17/2016), p. 2.
42 *Ibid*.
43 *Ibid*.
44 "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally" By K. Davis et al., The Commonwealth Fund, June 2014, http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror (Accessed 3/8/2016).
45 "National Health Expenditures Data: Table 1 - National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2013" Centers for Medicare & Medicaid Services, December 9, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/nationalHealthAccountsHistorical.html (Accessed 7/16/2015).
46 HHS, June 2015, p. 7.
47 K. Davis et al., June 2014.

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