

Value-Based Reimbursement: The First Steps (Part One of a Three-Part Series)

At present, the healthcare industry's transition towards *value-based reimbursement* is in full swing,¹ with providers and payors preparing for significant ties between the quality and efficiency of services and the payment for those services. A 2014 survey revealed that physicians anticipate that, within the next decade, *half* of physician compensation will be determined by value-based reimbursement models.² Consistent with this sentiment, in January of 2015, the *Centers for Medicare & Medicaid Services* (CMS) announced its goal that by the end of 2016, 85% of Medicare's *fee-for-service* (FFS) payments would be linked to quality in some manner, e.g., a portion of FFS payments would be determined by performance on measures of quality or efficiency.³ The current emphasis on quality and efficiency stands in stark contrast to previous reimbursement structures utilized by CMS. In 2005, the *Medicare Payment Advisory Commission* (MedPAC) reported that the Medicare program included counterproductive incentives regarding the quality of care delivered to Medicare beneficiaries. In its 2005 report, MedPAC observed that the Medicare program offered no incentive for providers to improve the quality of the healthcare services that they furnish; rather, the Medicare program frequently provided additional reimbursement to practitioners engaging in follow-up treatment to patients who suffered serious illness or injury while in their providers' care.⁴

This Health Capital Topics article is the first in a three-part series that will examine the evolution of value-based reimbursement in the United States. This first article in the series will explore the early initiatives that attempted to test the efficacy of paying healthcare practitioners based on the value of the services that they provided in a reimbursement environment dominated by an emphasis on volume. For the purposes of this series, "*value-based reimbursement*" will include those payment models that reimburse healthcare practitioners based on some condition (or set of conditions) related to the quality or cost efficiency of the services that those practitioners provide. This does not include certain initiatives or payment models (e.g., capitation) that may ultimately generate improvements in the quality or efficiency of care, but do not specifically require such improvements in order for practitioners to receive full payment.

The initial movements in this most recent shift toward value-based reimbursement in the United States began in the 1990s, when commercial payors and some state Medicaid programs were experimenting with programs that utilized financial payments to reward improvements in care.⁵ At the time, national health expenditures per capita were rising to historically high levels, reaching \$2,843 in 1990, compared to just \$355 in 1970.⁶ However, these soaring expenditures on healthcare services did not translate into better healthcare for Americans. Despite the fact that by 1997, the United States' national health expenditures per capita were more than double that of most industrialized countries, the United States consistently ranked at or near the bottom on commonly utilized measures of health outcomes (i.e., life expectancy and infant mortality).⁷ Within this environment of rising costs and concerns over quality incentives, in 1994, William Kissick described what he called the *iron triangle of healthcare*, i.e.; (1) access to care; (2) quality of care; and, (3) cost containment.⁸ Kissick's framework sought to illustrate the tension inherent in attempting to prioritize one of these three key goals of healthcare without sacrificing one or both of the others, explaining that in the preceding decades, the United States had expanded upon both access and quality, but had only achieved these advances at the expense of cost containment.⁹ Theoretically, an effective value-based reimbursement program could ameliorate the problem presented by the *iron triangle of healthcare*, by providing appropriate quality at the lowest possible cost; however, Kissick argued that this so-called solution could create unforeseen consequences for access to care.¹⁰

In December 2000, Congress passed the *Consolidated Appropriations Act, 2001* into law, which included a provision that instructed the *United States Department of Health and Human Services* (HHS) to conduct projects that would test, and, if they were effective, expand upon the use of financial incentives to: (1) improve coordination of care; (2) encourage investment in structures and processes that improve the efficiency of services; and, (3) reward providers for improving health care outcomes.¹¹ By the end of 2002, HHS had initiated voluntary programs that encouraged nursing homes and hospitals to report data pertaining to various quality metrics, in an early effort to, as then HHS Secretary Tom Thompson stated, "...make quality

*disclosure a robust and helpful element throughout our health care system.*¹²

However, by 2003, Congress and HHS had begun to pivot away from voluntary quality reporting, toward a system with more definite incentives, a shift that paralleled the directive of the *Consolidated Appropriations Act, 2001*. The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* stipulated that a hospital would suffer a reduction to its annual payment update for inpatient services, if that hospital did not report data pertaining to certain policies and procedures regarding patients suffering from heart attack, heart failure, or pneumonia.¹³ The *Reporting Hospital Quality Data for the Annual Payment Update Program* (later shortened to the *Hospital Inpatient Quality Reporting*, or “*Hospital IQR*,” Program)¹⁴ constitutes an early example of what is currently known as a *pay-for-reporting* (P4R) initiative. P4R programs are characterized by their utilization of financial incentives for providers that report data on certain pre-defined metrics,¹⁵ allowing the entities who govern the programs (and potentially consumers, if the program is designed to publish the quality information) to make informed decisions.¹⁶ The providers that are targeted by P4R programs vary between each individual initiative; for example, the Hospital IQR program applies to hospitals that bill Medicare for inpatient services.¹⁷ Years after the initiation of the Hospital IQR, HHS implemented similar P4R programs for outpatient hospitals and physicians, as directed by the *Tax Relief and Health Care Act of 2006*.¹⁸ Due to the importance of the Medicare program as a price setter in the healthcare industry,¹⁹ these early federal P4R programs constitute a significant milestone in the overall transition towards value-based reimbursement.

Beginning in 2003, as the Hospital IQR (known at the time as the *Reporting Hospital Quality Data for the Annual Payment Update Program*) was preparing to launch, HHS began to explore *pay-for-performance* (P4P) programs. P4P programs are value-based reimbursement models that are characterized by their utilization of financial incentives that are *directly* tied to measures of the quality or efficiency of care that a practitioner provides.²⁰ HHS’s early P4P demonstrations included: (1) the *Premier Hospital Quality Incentive Demonstration* (HQID), which began in 2003; and, (2) the *Physician Group Practice Demonstration* (PGP), which began in 2005.²¹ Like P4R, many individual P4P initiatives are restricted to the specific targets of a given program. This limitation may be a result of value-based reimbursement models’ reliance upon pre-defined metrics, as each type of provider may be best measured by standards that are specific to their setting. For example, the HQID measured participating hospitals’ performance related to certain inpatients, e.g., those undergoing coronary artery bypass grafts,²² a major surgical procedure.²³ This type of metric would be a poor fit for many physician practices; rather, a patient with coronary artery disease who sought treatment from a physician may receive ace inhibitor therapy,²⁴ a

treatment that was captured by the PGP’s quality metrics.²⁵

As demonstration projects, the HQID and PGP were relatively restricted in scope, applying to only a small sample of the totality of providers in the United States,²⁶ in order to test the viability of P4P initiatives.²⁷ Since the completion of the HQID and PGP demonstrations (in 2009 and 2010, respectively),²⁸ HHS has more aggressively pursued broader P4P programs, targeting a broader set of providers and settings of care (e.g., physician practices, hospitals, and hospices), predominantly as a result of provisions the *Patient Protection and Affordable Care Act* (ACA).²⁹ Notably, while early P4P initiatives focused on measures pertaining to the quality of care, more recent P4P programs have included a greater emphasis on cost efficiency and the appropriate utilization of services.³⁰

It should be noted that, while this article has focused on P4R and P4P initiatives, other types of programs may also drive healthcare practitioners to provide care that is high in quality, coordinated, and efficient. For example, in the early 1990s and the late 2000s, CMS conducted demonstrations examining the impact of bundled payments on the provision of healthcare services.³¹ However, these early bundled payment demonstrations did not tie provider reimbursement to measures of the cost or quality of care that the participating providers furnished;³² instead, these early bundled payment demonstrations relied on the limited reimbursement inherently associated with bundled payments to drive providers to improve their cost efficiency. Like P4P initiatives, federal bundled payment programs have continued to expand as a result of the passage of the ACA.³³

Regardless of the successes or failures of any of the early value-based reimbursement programs, together, these programs signify describe a deliberate procession towards an ultimate goal: to change the incentives present in United States healthcare delivery, such that providers are rewarded for improving the care that they deliver.³⁴ Whether or not the implementation of value-based reimbursement can definitively overcome Kissick’s *iron triangle of healthcare*, by providing improved quality and lower costs without reducing access to services, is yet to be seen.³⁵ As such, healthcare providers and administrators would be prudent to monitor the efficacy of value-based reimbursement as these programs become more widespread.

The next article in this series will continue to examine the evolution of value-based reimbursement in the United States, through an examination of the ACA, the impact of this landmark legislation on the value-based reimbursement programs extant at the time of its passage, and the ACA’s emphasis on shared savings and *accountable care organizations*.

1 “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, FACHE, ASA, New York, NY: American Institute of Certified Public Accountants, 2015, p. v.
- 2 "2015 Health Care Providers Outlook: United States" By Mitch Morris, MD, Deloitte, 2015, <http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-2015-global-hc-country-reports-011215.pdf> (Accessed 8/18/2015), p. 3.
 - 3 "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume" Centers for Medicare & Medicaid Services, January 26, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html> (Accessed 2/26/2016).
 - 4 "Medicare Payment Policy" Medicare Payment Advisory Commission, March 2005, http://www.medpac.gov/documents/reports/Mar05_EntireReport.pdf?sfvrsn=0 (Accessed 2/24/2016), p. 184.
 - 5 "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; "Pay-for-Performance in Health Care" By Jim Hahn, Congressional Research Service, December 12, 2006, <http://www.allhealth.org/briefingmaterials/crsreportingforcongress-s-pay-for-performanceinhealthcare-501.pdf> (Accessed 2/26/2016), p. 2.
 - 6 "Table 1: National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2014" Centers for Medicare & Medicaid Services, December 3, 2015, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html> (Accessed 2/26/2016).
 - 7 "Multinational Comparisons of Health Care: Expenditures, Coverage, and Outcomes" By Gerard F. Anderson, PhD, Johns Hopkins University, Center for Hospital Finance and Management, October 1998, http://www.commonwealthfund.org/~media/files/publications/ch-artbook/1998/oct/multinational-comparisons-of-health-care--expenditures--coverage--and-outcomes/anderson_multinational-pdf.pdf (Accessed 2/26/2016), p. 5-6.
 - 8 "Medicine's Dilemmas: Infinite Needs Versus Finite Resources" By William L. Kissick, MD, DrPH, New Haven, CT: Yale University Press, 1994, p. 2-3.
 - 9 *Ibid.*
 - 10 *Ibid.*, p. 4.
 - 11 "Consolidated Appropriations Act, 2001" Pub. L. No. 106-554, § 412, 114 Stat. 2763, 2763A-509 (December 21, 2000).
 - 12 "Secretary Thompson Welcomes New Effort to Provide Hospital Quality of Care Information" United States Department of Health and Human Services, December 12, 2002, <http://archive.hhs.gov/news/press/2002pres/20021212.html> (Accessed 2/25/2016).
 - 13 "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" Pub. L. No. 108-173, § 501, 117 Stat. 2066, 2289 (December 8, 2003); "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates" Federal Register Vol. 69, No. 96 (May 18, 2004), p. 28196, 28277-28278.
 - 14 "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).
 - 15 "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.
 - 16 CMS, "Hospital Inpatient Quality Reporting Program," September 13, 2013.
 - 17 *Ibid.*; "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates," May 18, 2004, p. 28196, 28277-28278.
 - 18 "Tax Relief and Health Care Act of 2006" Pub. L. No. 109-432, §§ 101, 109, 120 Stat. 2922, 2975, 2984 (December 20, 2006).
 - 19 "Medicare's Role in Determining Prices throughout the Health Care System: Mercatus Working Paper" By Roger Feldman et al., Mercatus Center, George Mason University, October 2015, <http://mercatus.org/sites/default/files/Feldman-Medicare-Role-Prices-oct.pdf> (Accessed 12/11/2015), p. 3-5.
 - 20 "Pay-for-Performance in Health Care" By Jim Hahn, Congressional Research Service, December 12, 2006, <http://www.allhealth.org/briefingmaterials/crsreportingforcongress-s-pay-for-performanceinhealthcare-501.pdf> (Accessed 2/26/2016), p. 2.
 - 21 Damberg et al., 2014, p. 1; "Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care – FACT SHEET" Centers for Medicare & Medicaid Services, December 2011, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HospitalPremierPresRelease-FactSheet.pdf> (Accessed 2/25/2016), p. 1; "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. 9.
 - 22 CMS, "Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care – FACT SHEET" December 2011, p. 1.
 - 23 "What is Coronary Artery Bypass Grafting?" National Heart, Lung, and Blood Institute, February 23, 2012, <http://www.nhlbi.nih.gov/health/health-topics/topics/cabg/> (Accessed 2/26/2016).
 - 24 "High Blood Pressure (Hypertension): Uses for ACE Inhibitors" May Clinic, February 1, 2014, <http://www.mayoclinic.org/diseases-conditions/high-blood-pressure/in-depth/ace-inhibitors/art-20047480?pg=2> (Accessed 2/26/2016).
 - 25 "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. 3.
 - 26 CMS, "Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care – FACT SHEET" December 2011, p. 1; CMS, "Medicare Physician Group Practice Demonstration: Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration" July 2011, p. 3.
 - 27 "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule" Federal Register Vol. 71, No. 79 (April 25, 2006), p. 23996, 24096.
 - 28 CMS, "Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care – FACT SHEET" December 2011, p. 1; CMS, "Medicare Physician Group Practice Demonstration: Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration" July 2011, p. 9.
 - 29 Damberg et al., 2014, p. 1-2.
 - 30 *Ibid.*, p. xiv.
 - 31 "Medicare Participating Heart Bypass Center Demonstration" Centers for Medicare & Medicaid Services, May 1, 2015, <https://innovation.cms.gov/Medicare-Demonstrations/Medicare-Participating-Heart-Bypass-Center-Demonstration.html> (Accessed 2/25/2016); "Medicare Acute Care Episode (ACE) Demonstration" Centers for Medicare & Medicaid Services, May 29, 2015, <https://innovation.cms.gov/initiatives/ACE/> (Accessed 2/25/2016).

32 “Medicare Participating Heart Bypass Center Demonstration: Executive Summary – Final Report” By Jerry Cromwell, PhD et al., Health Economics Research, Inc., July 24, 1998, https://innovation.cms.gov/Files/Migrated-Medicare-Demonstration-x/Medicare_Heart_Bypass_Executive_Summary.pdf (Accessed 2/25/2016), p. ES-2-ES-5; “Frequently Asked Questions about the

Acute Care Episode (ACE) Demonstration” Centers for Medicare & Medicaid Services, July 25, 2008, <https://innovation.cms.gov/Files/x/ACE-More-Info.pdf> (Accessed 2/25/2016), p. 8-9.
33 Damberg et al., 2014, p. 1-2.
34 MedPAC, March 2005, p. 184.
35 Damberg et al., 2014, p. xii-xiii.



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