HEALTH CAPITAL Topics
Volume 11
Issue 2
February 2018
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, ASA, FACHE, Publisher

Checking up on Healthcare's Hot Trend: Value-Based Reimbursement

To offset increasing costs and expenditures, healthcare reimbursement has begun shifting from *volume* to *value*, most recently manifested in the *2010 Patient Protection and Affordable Care Act* (ACA) and the *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA).[1] Although *value-based reimbursement* (VBR) programs are relatively new, recently-published preliminary evaluations of the programs have been disappointing, and, in conjunction with the organizational directives of newly-appointed *Centers for Medicare and Medicaid Services* (CMS) leadership, have prompted significant changes to existing VBR programs and the creation of a new VBR program.

The literature published to date has found that VBR programs are not achieving the intended results, and, in fact, indicates that VBR programs did not lead to improved patient care and outcomes.[2] A recent study found that the use of the *Value-Based Payment Modifier*[3] was not associated with better quality of care or lower spending, and did not provide any additional incentive for practices serving a disproportionately higher number of high-risk patients, e.g., complex or low income patients.[4] The findings from this study, and other literature, have suggested that pay-for-performance programs may exacerbate existing healthcare disparities either by financially penalizing, or not providing enough support to, hospitals that serve a greater proportion of these high-risk patients.[5] Additionally, two separate studies from *Health Affairs* and the *U.S. Government Accountability Office* found that the *Hospital Value-Based Purchasing Program*[6] rewards hospitals for maintaining low costs, even if they have low quality scores.[7] These results suggest that CMS's goals of "*Better Care. Smarter Spending. Healthier People*"[8] are not being furthered by some of its current VBR models, and the unintended consequences of these policies may be the sacrifice of higher quality care in the name of cost containment. Perhaps as a result of this research, or due to political ideology, the current administration has developed a new bundled payment model while relaxing the participation requirements for physicians in other VBR programs.

On January 9, 2018, CMS announced the launch of the *Bundled Payments for Care Improved Advanced model* (BPCI Advanced).[9] This new, voluntary payment model was unveiled subsequent to the November 2017 cancellation of the previously mandated hip fracture and cardiac bundled payment models and the reduction of the *Comprehensive Care for Joint Replacement Model* (CJR) program.[10] In the press release related to the hip fracture and cardiac bundled payment models cancellation, CMS expressed its intention to release new voluntary payment bundles in order to "*offer opportunities to improve quality and care coordination while lowering spending…[by] focusing on developing different bundled payment models and engaging more providers…to drive health system change while minimizing burden and maintaining access to care*."[11]

The BPCI Advanced payment program is considered an *Advanced Alternative Payment Model* (Advanced APM) under the *Quality Payment Program* (QPP) established by MACRA.[12] In this program, participating providers can earn incentive payments for 32 different clinical episodes (29 inpatient and 3 outpatient)[13] if all of the beneficiary's expenditures during that episode and the subsequent 90-day period fall below a specified spending target, while concurrently maintaining or improving upon seven specific quality measures.[14] From January 11, 2018 until March 12, 2018,[15] providers may apply for participation in the initial version of the BPCI Advanced payment model, which will run from October 1, 2018 through December 31, 2023.[16]

On January 11, 2018, the *Medicare Payment Advisory Commission* (MedPAC) decided, in a 14 to 2 vote, to recommend that Congress repeal and replace the *Merit-based Incentive Payment System* (MIPS).[17] MIPS is also part of the QPP established under MACRA.[18] MedPAC had previously voiced dissatisfaction with the design of MIPS, stating in a June 2017 report that MIPS "*…is unlikely to succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program reward clinicians based on value*."[19] The report also noted concerns that submission of quality and outcome measures as required under MIPS may become too burdensome for clinicians.[20] MedPAC recommended a replacement program for MIPS, in which providers would be evaluated on a set of population outcome measures as part of a group of physicians, and be compared against other groups to obtain incentive payments.[21] MedPAC will provide further

(Continued on next page)

recommendations regarding potential replacement models to Congress in its March 2018 report.[22]

Shortly after being sworn in as the fifteen Administrator of CMS in March 2017, Seema Verma announced in a *Wall Street Journal* op-ed that, "*[t]his administration plans to lead the [CMS] Innovation Center in a new direction,*" which included plans not only to continue the "*shift away from fee-for service…toward a system that holds providers accountable for outcomes…*" but also to "*increase flexibility by providing more waivers from current requirements*."[23] On February 12, 2018, at the *CMS Quality Conference*, Verma reaffirmed this commitment, stating: "*Let me be clear: Moving away from fee-for-service is something that [new Department of Health and Human Services] Secretary [Alex] Azar and I are committed to, and ensuring quality is an essential component of this…We want to support quality, but there have been unintended negative consequences of too many quality measures*."[24] Indications derived from CMS policy changes throughout the first year of Verma's tenure suggest a movement from requiring physicians to participate in programs that include some form of downside risk to voluntary programs with fewer standardized metrics and reporting requirements.

Aside from political motivations, the concern that current VBR models are not appropriately incentivizing provider innovation and quality improvement (potentially due to fundamental flaws in program design) has likely prompted some of the recent (and suggested) changes in the QPP. While VBR programs will likely continue (at least in the short term) to shift from a mandatory to a voluntary basis under the current administration, it is yet unclear whether this latest VBR iteration will impact provider quality of care and spending levels, which may prompt CMS to continue to adjust, refine, or make wholesale changes to its programs. However, what is clear is that in order to determine the effectiveness of this iteration of VBR models (or any other model which reimbursement is based in part on higher quality care and lower cost), these programs will require significant provider participation. Otherwise, the U.S. healthcare industry may be no closer to the achievement of the "*Triple Aim of Healthcare*" than it was prior to the identification of a need for healthcare reform.

---

1 "CMS' Value-Based Programs" Centers for Medicare and Medicaid Services, November 9, 2017, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html (Accessed 12/28/17).

2 "Road to Value-Based Payment Bumpy in 2017" By Maria Castellucci, Modern Healthcare (December 27, 2017), http://www.modernhealthcare.com/article/20171227/NEWS/171229948/road-to-value-based-payment-bumpy-in-2017 (Accessed 12/28/17).

3 The Value Modifier reimburses physicians based upon performance that compares quality and cost of care ("Value-Based Payment Modifier" Centers for Medicare & Medicaid Services, September 21, 2017, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html (Accessed 1/22/18).)

4 "The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities" By Eric T. Roberts, Alan M. Zaslavsky, and J. Michael McWilliams, Annals of Internal Medicine, November 28, 2017, http://annals.org/aim/article-abstract/2664654/value-based-payment-modifier-program-outcomes-implications-disparities (Accessed 1/15/18); "Practices with High-Risk Patients are Vulnerable to Value-Based Payment Penalties" By Maria Castellucci, Modern Healthcare (November 29, 2017), http://www.modernhealthcare.com/article/20171129/NEWS/171129913/practices-with-high-risk-patients-are-vulnerable-to-value-based (Accessed 1/15/18).

5 Eric T. Roberts, Alan M. Zaslavsky, and J. Michael McWilliams, November 28, 2017; "Could Pay-for-Performance Worsen Health Disparities?" By Mubeen Shakir, Katrina Armstrong, and Jason H. Wasfy, Journal of General Internal Medicine (January 4, 2018), https://link.springer.com/article/10.1007%2Fs11606-017-4243-3 (Accessed 1/16/18).

6 The HVBP scores and rewards hospitals for improved performance over time and in comparison to peers for a specific set of quality measures ("MLN Booklet: Hospital Value-Based Purchasing" Centers for Medicare & Medicaid Services, September 2017, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf (Accessed 1/22/18), p. 2-6).

7 "Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals" By Anup Das et al., Health Affairs, Vol. 35, No. 5 (May 2016); "Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do not Qualify for Bonuses" United States Government Accountability Office, June 2017, https://www.gao.gov/assets/690/685586.pdf (Accessed 12/29/17).

8 "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume" Centers for Medicare and Medicaid Services, Press Release, January 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html (Accessed 1/22/18); "Better Care. Smarter Spending. Healthier People: Improving Quality and Paying for What Works" Centers for Medicare and Medicaid Services, Press Release, March 3, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html (Accessed 1/22/18).

9 "CMS Announces New Payment Model to Improve Quality, Coordination, and Cost-Effectiveness for Both Inpatient and Outpatient Care" Centers for Medicare & Medicaid Services, Press Release, January 9, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-01-09.html (Accessed 1/15/18).

10 "CMS Finalizes Changes to the Comprehensive Care for Joint Replacement Model, Cancels Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model" Centers for Medicare and Medicaid Services, Press Release, November 30, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-30.html (Accessed 12/29/17); For an in-depth analysis on the implications of these cancellations see Health Capital Topics "Now You See It, Now You Don't: Bundled Payment Programs Cancelled" Vol. 10, Issue 10 (October 2017), https://www.healthcapital.com/hcc/newsletter/10_17/PDF/CJR.pdf (Accessed 12/29/17).

11 *Ibid.*

12 Centers for Medicare & Medicaid Services, Press Release, January 9, 2018.

13 The three outpatient clinical episodes include: percutaneous coronary intervention; cardiac defibrillator; and, back & neck except spinal fusion. Examples of the 29 inpatient clinical episodes include: acute myocardial infarction; cellulitis; fractures of the femur and hip or pelvis; gastrointestinal hemorrhage; renal failure; sepsis; stroke; and, urinary tract infection, among others. "BPCI Advanced: Fact Sheet" Centers for Medicare & Medicaid Services, January 2018,

(Continued on next page)

https://innovation.cms.gov/Files/fact-sheet/bpci-advanced-generalfs.pdf (Accessed 1/15/18), p. 3.

14 "BPCI Advanced: Fact Sheet" Centers for Medicare & Medicaid Services, January 2018, https://innovation.cms.gov/Files/fact-sheet/bpci-advanced-generalfs.pdf (Accessed 1/15/18), p. 2-3, 7; Centers for Medicare & Medicaid Services, Press Release, January 9, 2018; "Centers for Medicare & Medicaid Services, January 12, 2018.

15 *Ibid*, p. 1.

16 *Ibid.*

17 "MedPAC Votes 14-2 to Junk MIPS, Providers Angered" By Virgin Dickson, Modern Healthcare (January 11, 2018), http://www.modernhealthcare.com/article/20180111/NEWS/180119963 (Accessed 1/12/18). MedPAC is an independent, nonpartisan legislative agency of 17 appointed members, established under the Balanced Budget Act of 1997, that provides analysis and policy advice to Congress and the Department of Health and Human Services regarding the Medicare program ("About MedPAC" Medicare Payment and Advisory Commission, http://www.medpac.gov/-about-medpac- (Accessed 1/22/18). Note that the government has no legal requirement to follow MedPAC recommendations.)

18 "Chapter 5: Redesigning the Merit-Based Incentive Payment System and Strengthening Advanced Alternative Payment Models" The Medicare Payment Advisory Commission in "Report to the Congress: Medicare and the Health Care Delivery System," June 2017, http://www.medpac.gov/docs/default-source/reports/jun17_ch5.pdf?sfvrsn=0 (Accessed 1/15/18), p. 159. Note that MIPS and APMs under the QPP were established to replace the sustainable growth rate system that was repealed under MACRA, in order to create a physician payment program that better tied payments to measures to improve quality and cost of care.

19 *Ibid*, p. 160.

20 *Ibid.*

21 Virgin Dickson, January 11, 2018, p. 160-161.

22 *Ibid.*

23 "Medicare and Medicaid Need Innovation: Trump's HHS Seeks to Encourage Health-Care Competition" By Seema Verma, The Wall Street Journal, September 19, 2017, https://www.wsj.com/articles/medicare-and-medicaid-need-innovation-1505862017 (Accessed 1/22/18).

24 "Verma Renews Commitment to Value-Based Models" By Steven Porter, HealthLeaders Media, February 12, 2018, http://www.healthleadersmedia.com/quality/verma-renews-commitment-value-based-models# (Accessed 1/22/18).

(Continued on next page)

HCC
HEALTH CAPITAL CONSULTANTS

(800)FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- HCC Home
- Firm Profile
- HCC Services
- HCC Experts
- Clients & Projects
- HCC News
- Upcoming Events
- Contact Us
- Email Us

HCC Services

- Valuation Consulting
- Commercial Reasonableness Opinions
- Commercial Payor Reimbursement Benchmarking
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Consulting
- Industry Research Services

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC). Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group Management Association (VMGMA) and the Midwest Accountable Care Organization Expo. Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.

Jessica L. Bailey-Wheaton, Esq., is Vice President and General Counsel of **HEALTH CAPITAL CONSULTANTS** (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.

Daniel J. Chen, MSF, is a Senior Financial Analyst at **HEALTH CAPITAL CONSULTANTS** (HCC), where he develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition, Mr. Chen prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services, and applies utilization demand and reimbursement trends to project professional medical revenue streams, as well as ancillary services and technical component (ASTC) revenue streams. Mr. Chen has a Master of Science in Finance from Washington University St. Louis.