Value-Based Purchasing in the U.S. Health Care System

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Value-based Purchasing

- Value-based purchasing is a term that has been used to describe a myriad of ways in which entities that buy health insurance or health care account for value in contracting and payment (we will focus on health care)
- Value = net benefit (benefits minus costs)
- Mechanisms:
  - Selective contracting
  - Performance measurement and reporting
  - Pay for performance

Value-Based Purchasing in the U.S.: Medicare

- Medicare, the dominant public payer in the U.S., has a long history with measurement, reporting, selective contracting and pay for performance
  - Hospitals
  - Private health insurance plans (Medicare Advantage)
  - Health systems (ACOs)
  - Physicians
- Current approach to reform is two-pronged: providers can opt in to "alternative payment models" or be subjected to incremental changes

Value and Payment

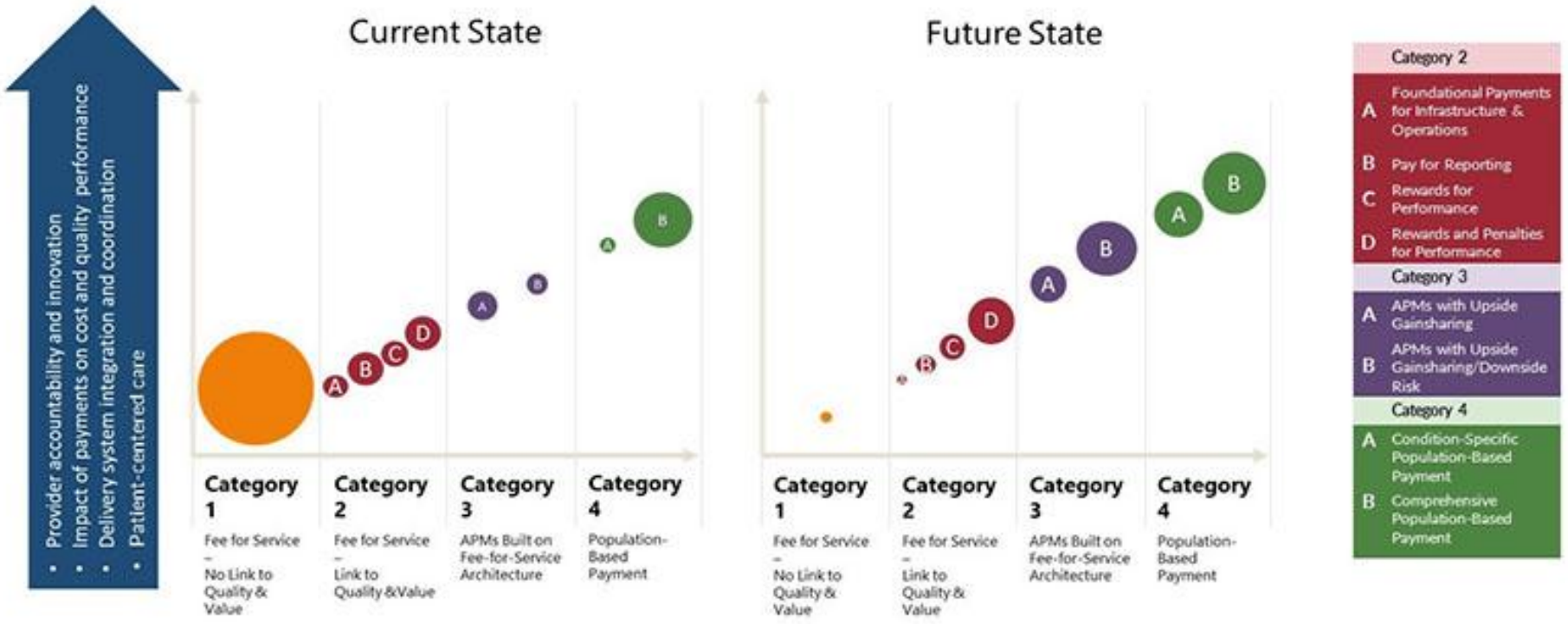

Figure 1. The circles in this graphic estimate the relative degree of payment model activity in each category and do not represent exact figures or percentages.

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Accountable Care Organizations

- Both a delivery model and a payment vehicle
- Typically patients attributed retrospectively because Medicare patients do not have a fixed PCP (not Pioneer)
- Shared savings relative to actuarial prediction of total costs
- Quality indicators both a threshold and multiplier for savings
- Providers opt in; some requirements for participation:
  - Governance
  - Primary care
  - IT capacity

ACO Overview

ACO Growth Over Time

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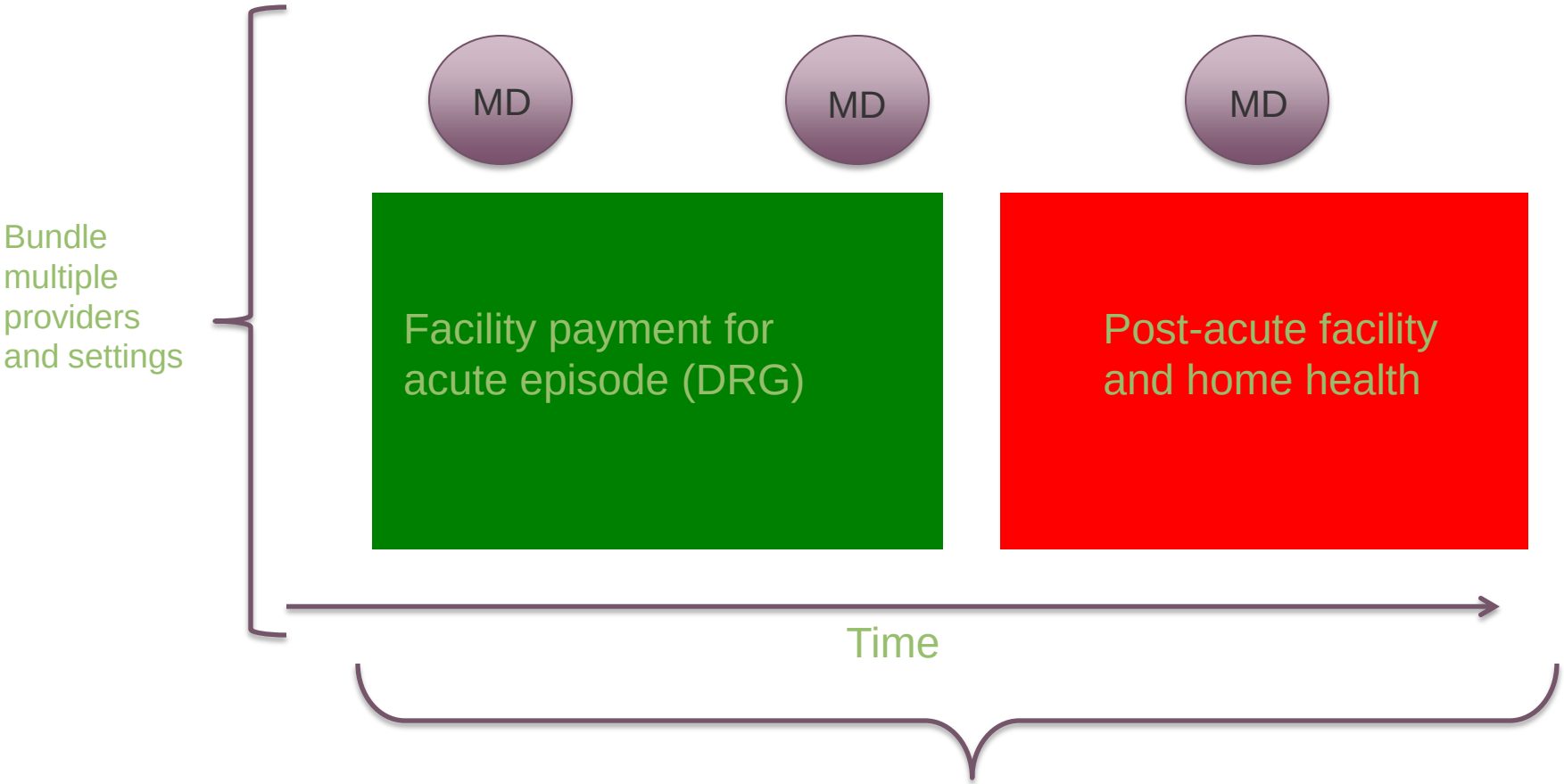
Source: Muhlestein, D., and M. McClellan. "Accountable care organizations in 2016: private and public-sector growth and dispersion." *Health Affairs Blog*.

Bundled Payment: Payments for an Episode of Care



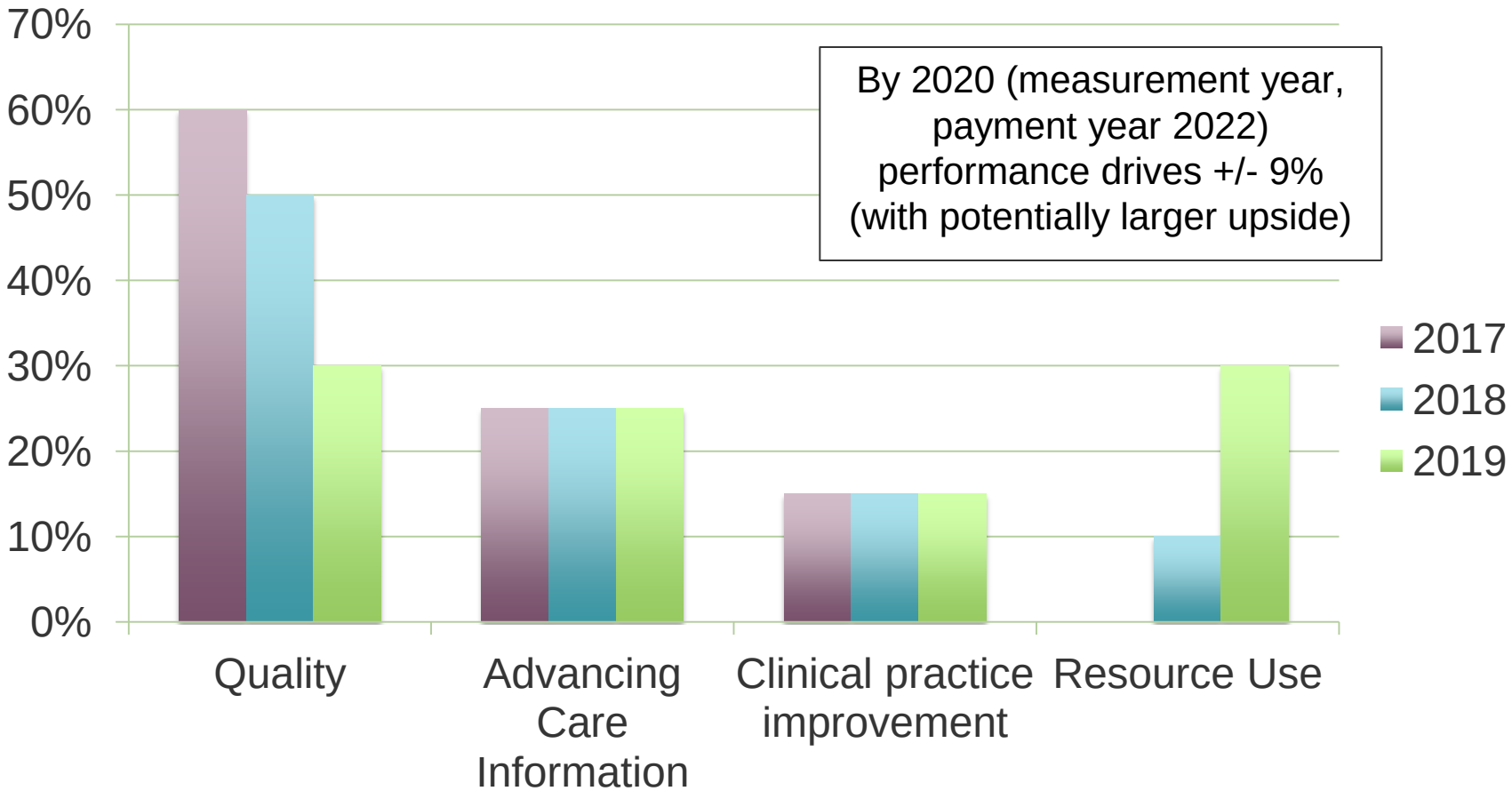
Evolving Baseline for Hospital Incentives

- Hospital value based purchasing
  - FY13 Process measures of quality, HCAHPS
  - FY14 Added cost per beneficiary, outcome measures
  - Phased in: as of FY17 up to **2%** bonus or penalty
- Hospital Readmission Reduction Program
  - Penalties up to **3%** of total Medicare payments
  - "Higher than expected" readmission rates
- Hospital Acquired Condition Reduction Program
  - Poorest performing 25% paid **1%** less

Repeal of Sustainable Growth Rate and Merit-based Incentive Payment System (MIPS)

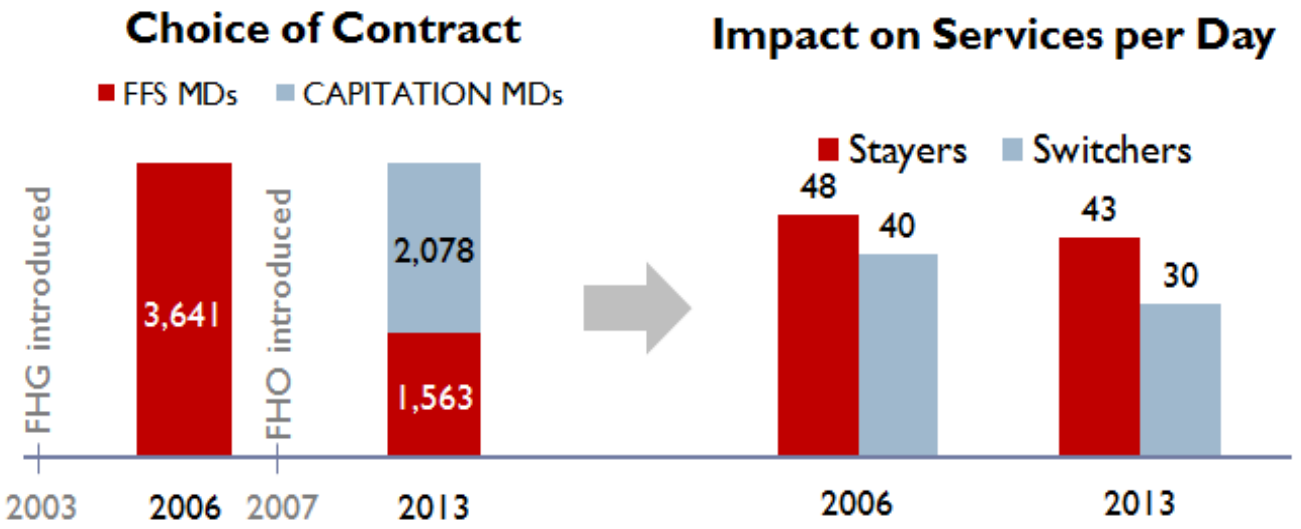
- After 20 years, Medicare is finally changing physician payment
- The “sustainable growth rate” policy, which failed to contain spending, was repealed and replaced with pay for performance (MIPS)
- These changes affect those physicians who have not opted into new funding models (about 85%)

How Will MIPS Work?



Evidence of Impact

Impact on Quantity: Primary Care FFS vs. Capitation



Total Impact	=	Selection Effect	+	Incentive Effect
-13 (30-43)	=	-8 (40-48)	+	-5 (30-40)-(43-48)

Source: Kantarevic and Kralj (2015), Health Economics

What About Pay for Performance?

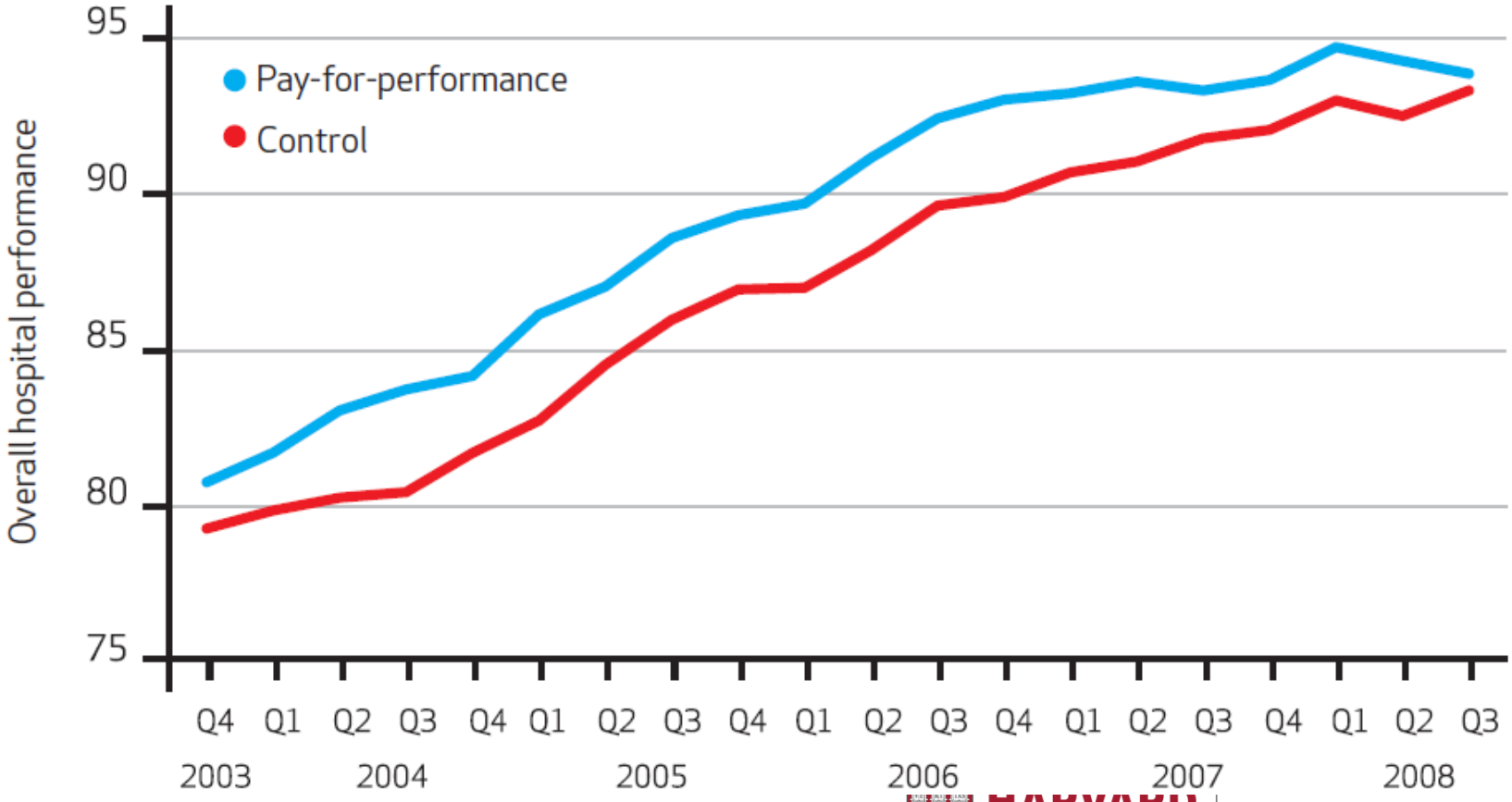
- While volume incentives may have some relationship to system goals they are undifferentiated -- more is more
- Performance measurement and payment represent efforts to better target/align physicians with payer or system goals
  - Evidence-based processes
  - Intermediate outcomes
  - Participation in non-billable activities ("citizenship") that benefit the group

How Many Ways Can You Say Null or Modest (i.e. disappointing)?

- HMO studies from the 1990s found no effect of substantial bonuses for immunization (Hillman, Fairbrother)
- Medicare hospital pay for performance had little or no effect (Lindenauer, Ryan, Jha, Joynt, and others)
- Physician pay for performance had little or no effect in major U.S. demonstrations (Rosenthal, Mullen, Pearson) – even with enormous bonuses in the NHS! (Campbell)

Impact of Pay for Performance

Average Overall Performance In Pay-For-Performance And Control Hospitals, Fiscal Years 2004–08



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Alternative Payment Models

- Bundled Payment for Care Initiative reduced spending on orthopedic procedure episodes, through reducing post-acute care (Dummit et al. 2016) -- prior work in the 1990s found the same for CABG
- Medicare ACO results mixed: early adopters showed savings and ACOs without hospitals performed better (McWilliams et al. 2016)
- Comprehensive Primary Care Initiative: Practice improvements but no savings after two years (Dale et al. 2016)

Where Does This Leave Us (and Alberta)?

- Most agree that we are not getting enough value for money in health care
- Evidence is clear that fee for service increases spending while quality gaps remain -- at a minimum it cannot encourage unreimbursed care (e.g., coordination): salary and capitation allow more room for innovation, non-visit based care
- Much harder to point to a single best alternative using evidence (or theory): mixed models and experiments are needed
- Opt-in models have some attraction, but lots of risk
- Clearly, improving health care access, quality and affordability goes well beyond funding reform