UPMC LIFE CHANGING MEDICINE

Value Based Reimbursement: Ten Years After the Affordable Care Act

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Chief Advanced Practice Officer, UPMC

I have no disclosures

Objectives

Review the path leading to value-based health care reimbursement models

Review the outcomes of value-based reimbursement models

Determine whether VBR models have changed the focus from volume-based reimbursement models

UPMC's IDFS Strategy

Insurance Services Division

- Premium Dollar
- New Business Models
- Access to Patients
- Product Design

"Payor-Provider Initiatives"

Align initiatives so patients and quality are always first

Health Services Division

- Academic Excellence and Research
- Full Continuum of Care
- Geographic Coverage

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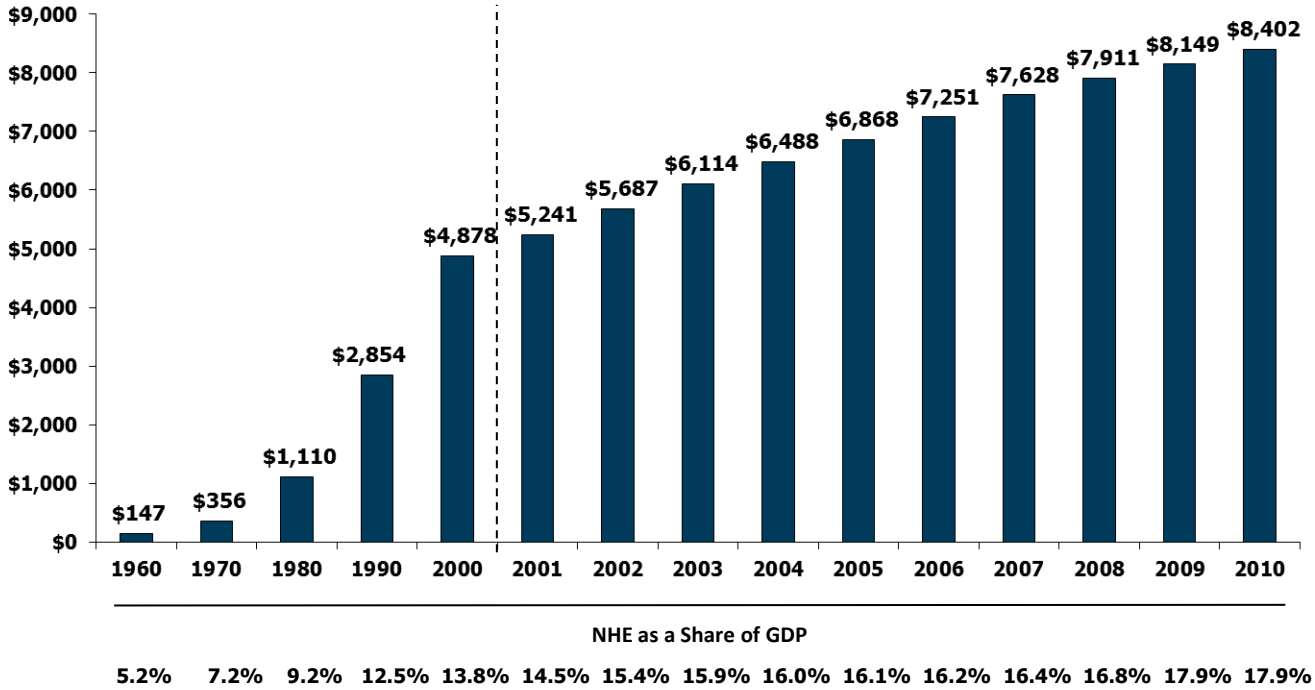
How did we get here?
A brief history…

What Lead to the ACA:
National Health Expenditures per Capita, 1960-2010



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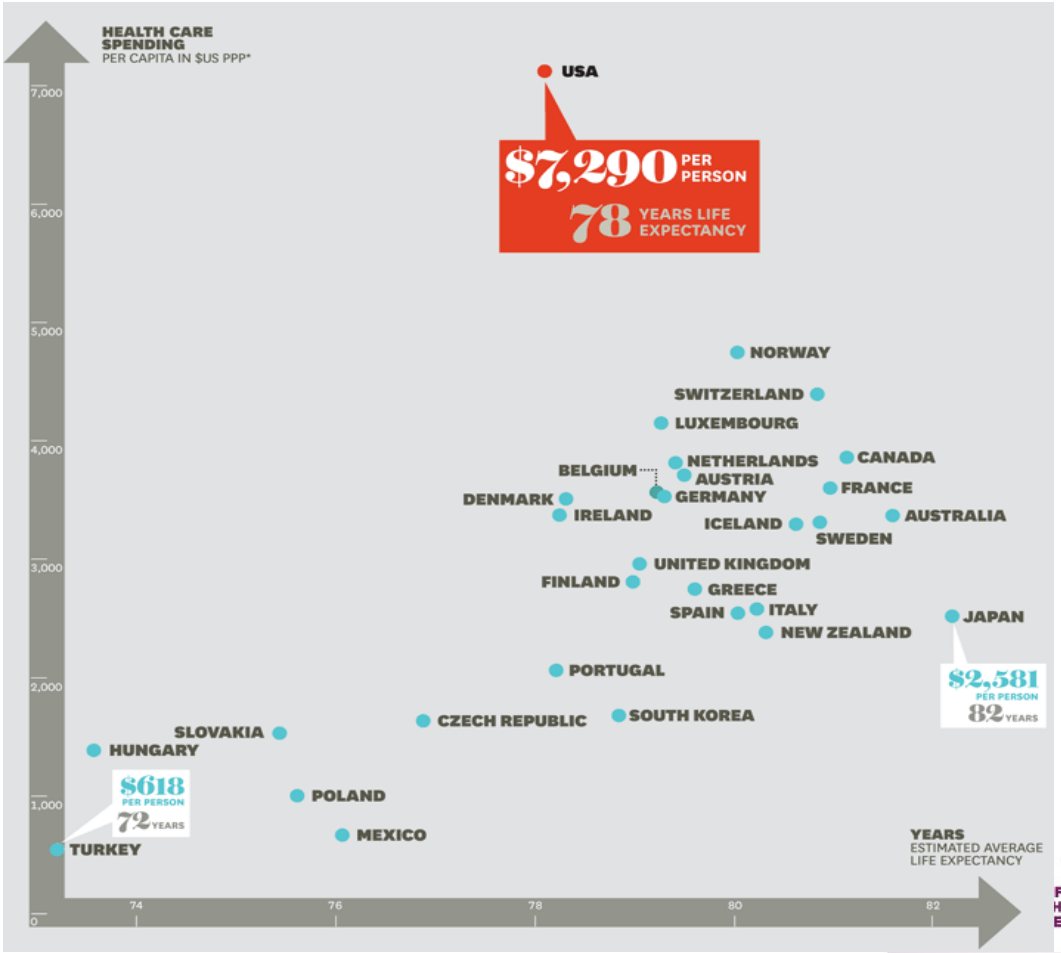
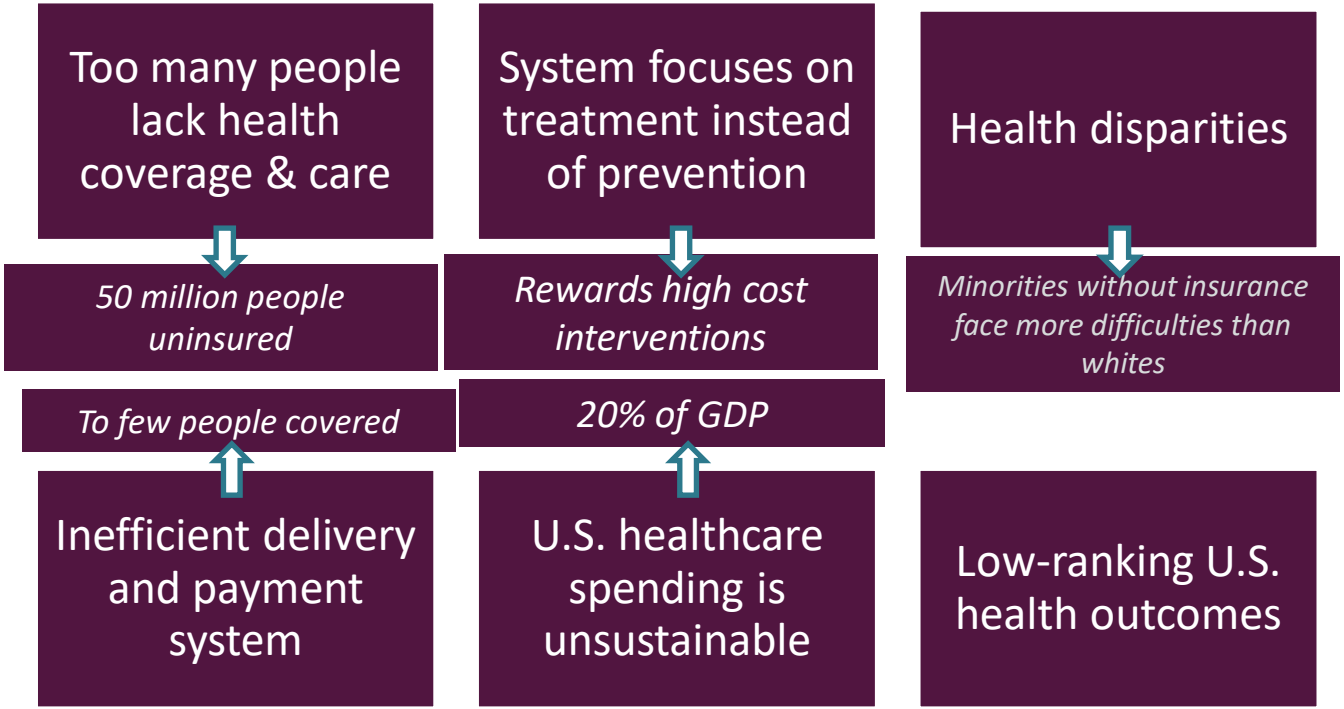
The U.S. Health Care System: Price and Performance Concerns

- The U.S. spends more on health care per capita than other peer countries
- U.S. ranks in the bottom 25% of those countries on life expectancy



Source: Harvard Business Review, “Spotlight on Fixing Health Care”, April 2010.

Health care reform was necessary…



For more information, see APHA's "Why do we need the Affordable Care Act," at http://www.apha.org/advocacy/Health+Reform/ACAbasics/.

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The Patient Protection and Affordable Care Act (ACA)

March 23, 2010

Moving toward the triple aim…

- improving the individual experience of care;
- improving the health of populations; and
- reducing the per capita costs of care for populations

http://www.healthcare.gov/law/full/.

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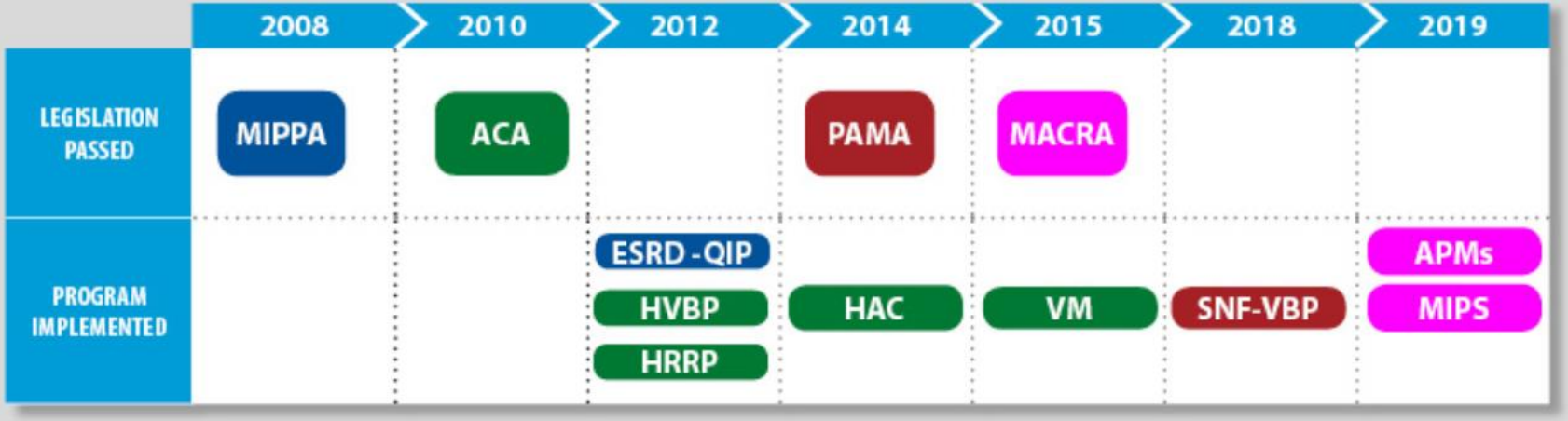
Obamacare and the beginning of Value Based Reimbursement

- Created the Center for Medicare and Medicaid Innovation (CMMI)
- Allocated $10 billion dollars over 10 years to develop / test new payment and care delivery models

VALUE-BASED PROGRAMS



LEGISLATION

ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models
ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
HACRP: Hospital-Acquired Condition Reduction Program
HRRP: Hospital Readmissions Reduction Program
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Good quality / outcome = Bonuses

Bad Quality / Outcome = Penalties

Did Value Based Reimbursement Diminish the Focus on Volume?

Hary
Busi
Revi

https://i.guim.co.uk/img/media/805964dd561b2c3ce53deca5d6e976a9fe58e0a6/0_225_3600_2159/master/3600.jpg?width=1200&height=900&quality=85&auto=format&fit=crop&s=57bd1ff705e0031dbe5d8344c36f2b61

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Did Value Based Reimbursement Kill the Volume Zombie?

https://media.wired.com/photos/5a3d96ff7ed4041c061456d8/master/pass/l4d1.jpg

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Eleven Years of Data

The Commonwealth Fund

Evidence from a Decade of Innovation: The Impact of the Payment and Delivery System Reforms of the Affordable Care Act

HealthAffairs

A Decade of Value-Based Payment: Lessons Learned And Implications For The Center For Medicare And Medicaid Innovation, Part 1

Hannah L. Crook, Robert S. Saunders, Rachel Roiland, Aparna Higgins, Mark B. McClellan

JUNE 9, 2021 10.1377/hblog20210607.656313

- ✓ National Payment Reforms
- ✓ Episode Based Payment Initiatives
- ✓ Primary Care Transformation

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CMS.gov
Centers for Medicare & Medicaid Services

Hospital Readmissions Reduction Program (HRRP)

- In place since 2012
- Six conditions / procedures 30-day risk-standardized unplanned readmission measures in the program:
  - AMI
  - COPD
  - CHF
  - Pneumonia
  - Coronary artery bypass graft (CABG) surgery
  - Elective THA/TKA

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CMS.gov
Centers for Medicare & Medicaid Services

Hospital Readmissions Reduction Program (HRRP)

- Payment reduction calculation for each hospital based on its performance during a rolling performance period.
- The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospital payments.
- Payment reductions are applied to all Medicare fee-for-service base operating diagnosis-related group payments during the FY (October 1 to September 30).
- The payment reduction is capped at 3 percent (that is, a payment adjustment factor of 0.97).

The Commonwealth Fund

Evidence from a Decade of Innovation: The Impact of the Payment and Delivery System Reforms of the Affordable Care Act

- 2019: 83% of hospitals penalized
- 2,583 penalized up to $563 million for readmissions

- MIXED RESULTS:
  - Some reductions, but not statistically significant
  - ***Increased mortality???***

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

JAMA | Original Investigation

Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia

Rishi K. Wadhera, MD, MPP, MPhil; Karen E. Joynt Maddox, MD, MPH; Jason H. Wasfy, MD, MPhil; Sebastien Haneuse, PhD; Changyu Shen, PhD; Robert W. Yeh, MD, MSc

JAMA. 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

Key Points

Question Was the announcement and implementation of the Hospital Readmissions Reduction Program (HRRP) associated with an increase in patient-level mortality?

Findings In this retrospective cohort study that included approximately 8 million Medicare beneficiary fee-for-service hospitalizations from 2005 to 2015, implementation of the HRRP was associated with a significant increase in trends in 30-day postdischarge mortality among beneficiaries hospitalized for heart failure and pneumonia, but not for acute myocardial infarction.

JAMA | Original Investigation

Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia

Rishi K. Wadhera, MD, MPP, MPhil; Karen E. Joynt Maddox, MD, MPH; Jason H. Wasfy, MD, MPhil; Sebastien Haneuse, PhD; Changyu Shen, PhD; Robert W. Yeh, MD, MSc

JAMA. 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

Meaning There was a statistically significant association with implementation of the HRRP and increased post-discharge mortality for patients hospitalized for heart failure and pneumonia, but whether this finding is a result of the policy requires further research.

CMS.gov
Centers for Medicare & Medicaid Services

Hospital-Acquired Condition Reduction Program

- In place since 2014
- Goal is to reduce **preventable** hospital-acquired conditions through a 1% financial penalty for hospitals in the top quartile for preventable HACs.

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- Produced an annual average reduction of 4.5% of HACS between 2010 and 2017 BUT…
- ***Does not appear to incentivize improvement with increasing penalties…***

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

BMJ open accessible medical research

Changes in hospital safety following penalties in the US Hospital Acquired Condition Reduction Program: retrospective cohort study

Roshun Sankaran,[1,2] Devraj Sukul,[2] Ushapoorna Nuliyalu,[3,4] Baris Gulseren,[1] Tedi A Engler,[1,3] Emily Arntson,[1,2] Hanna Zlotnick,[5] Justin B Dimick,[2,3,4] Andrew M Ryan[1,3,4]

the bmj | *BMJ* 2019;366:l4109 | doi: 10.1136/bmj.l4109

- 708 hospitals examined who were penalized under HACRP FY 2015
- Penalized hospitals more likely to be large teaching institutions with greater share of patients with low socioeconomic status than non-penalized hospitals
- Penalization NOT associated with significant changes in rates of HACs, 30-day readmissions or 30-day mortality.

HACRP could be exacerbating inequities in care.

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CMS.gov
Centers for Medicare & Medicaid Services

The Hospital Value-Based Purchasing (VBP) Program

- In place since 2013
- Adjusts payments to hospitals based on their performance on measures of clinical outcomes, patient and community engagement, safety, and efficiency.

CMS.gov
Centers for Medicare & Medicaid Services

The Hospital Value-Based Purchasing (VBP) Program

- Withholds participating hospitals' Medicare payments by 2%. Looks at
  - Mortality and complications
  - Healthcare-associated infections
  - Patient safety
  - Patient experience
  - Efficiency and cost reduction
- Payments adjusted based on total performance measure by measure against all hospitals OR how much improvement in performance compared to the prior period.

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Studies have shown NO significant difference in quality of care or mortality between participating hospitals and controls

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BMJ open accessible medical research

Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study

Jose F Figueroa,[1,3] Yusuke Tsugawa,[1] Jie Zheng,[1] E John Orav,[2,3] Ashish K Jha[1,4]

thebmj | *BMJ* 2016;353:i2214 | doi: 10.1136/bmj.i2214

- 618 hospitals from 2008 to 2013
- 30-day risk adjusted mortality for acute myocardial infarction, heart failure, and pneumonia
- Non-incentivized, medical conditions were the comparators
- Second outcome measure was to determine whether the introduction of the HVBP program benefited poor performers at baseline.

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The NEW ENGLAND JOURNAL of MEDICINE

Changes in Hospital Quality Associated with Hospital Value-Based Purchasing

Andrew M. Ryan, Ph.D., Sam Krinsky, M.A., Kristin A. Maurer, M.P.H., and Justin B. Dimick, M.D., M.P.H.

June 15, 2017
N Engl J Med 2017; 376:2358-2366
DOI: 10.1056/NEJMsa1613412

- Looked at first four years of the program (2012-2017)
- Evaluated whether quality improved more in acute care hospitals that were exposed to HVBP than in control hospitals
- HVBP not associated with significant reductions in mortality among patients with AMI or CHF.
- Did improve mortality reductions in PNA

BMJ open accessible medical research

Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study

Jose F Figueroa,[1,3] Yusuke Tsugawa,[1] Jie Zheng,[1] E John Orav,[2,3] Ashish K Jha[1,4]

thebmj | *BMJ* 2016;353:i2214 | doi: 10.1136/bmj.i2214

The introduction of the HVBP program was not associated with an improvement in 30 day mortality of Medicare beneficiaries admitted to US hospitals

Nations considering similar pay for performance programs may want to consider alternative models to achieve improved patient outcomes

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CMS.gov
Centers for Medicare & Medicaid Services

Bundled Payments for Care Improvement (BPCI) Initiative:

- Comprised of four broadly defined models of care linking payments for multiple beneficiaries received during an episode of care.
- Organizations receive payment based on financial and performance accountability for episodes of care aimed to increase quality and care coordination at a lower cost to Medicare.
  - Model 1: Acute Care Hospital Stay Only (2013-2016, 24 hospitals)
  - Model 2: Acute & Post-Acute Care Episode (2013-2018, 422 hospitals, 277 physician group practices)
  - Model 3: Post-Acute Care Only (2013-2018, 873 SNFs, 116 home health agencies, 9 inpatient rehab, one LTC, 144 group practices)
  - Model 4: Prospective Acute Care Hospital Stay Only (2013-2018, 23 hospitals)

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Centers for Medicare & Medicaid Services

Bundled Payments for Care Improvement (BPCI) Initiative:

- Model 1:
  - *No consistently statistically significant positive OR negative impact on cost per episode of or health outcomes*
  - Less successful for medical than surgical conditions
  - Hospital participation for common medical conditions not associated with reductions in Medicare payments, ED use, readmissions or mortality

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

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CMS.gov
Centers for Medicare & Medicaid Services

Bundled Payments for Care Improvement (BPCI) Initiative:

- Models 2-4:
  - *Significantly* reduced per episode payment with NO reduction in quality
  - Payment reduction did not translate into net savings for CMS
  - Less successful for medical than surgical conditions
  - Hospital participation for common medical conditions was not associated with reductions in Medicare payments, emergency department use, readmissions, or mortality.

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

CMS.gov
Centers for Medicare & Medicaid Services

Comprehensive Care for Joint Replacement Model

- 2016-Present
- Hospitals in designated areas receive single, retrospective payment for hip and knee replacements that includes inpatient hospitalization, postacute care, and other physician services.
- Like BPCI, participants receive payments if total spending is below predetermined target prices

The Commonwealth Fund

Evidence from a Decade of Innovation: The Impact of the Payment and Delivery System Reforms of the Affordable Care Act

CMS.gov
Centers for Medicare & Medicaid Services

Comprehensive Care for Joint Replacement Model

- Statistically significant reduction in payments (3.7% reduction) from 2016 to 2017, BUT….
- …when accounting for reconciliation payments to practices, program resulted in nonsignificant 0.5% reduction in payments.
- No change in quality.

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

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CMS.gov
Centers for Medicare & Medicaid Services

Comprehensive Primary Care Plus

- 2017-present
- 2851 practices and 55 payers participating in 18 regions as of 2019
- Participating practices receive performance-based incentive payments rather than share in savings

CMS.gov
Centers for Medicare & Medicaid Services

Independence at Home Demonstration

- 2012-present
- 14 sites
- Practices provide home-based primary care for chronically ill Medicare beneficiaries using teams of providers.
- Practices that achieve cost reductions while maintaining or improving quality share in savings to Medicare.

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CMS.gov
Centers for Medicare & Medicaid Services

Independence at Home Demonstration

- Lowered Medicare expenditures by $25 million
  - Not clear if net savings were produced when considering incentive payments paid to practices.
- Significant decrease in ED visits and hospitalizations.
- Improved beneficiary and caregiver satisfaction.

https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act

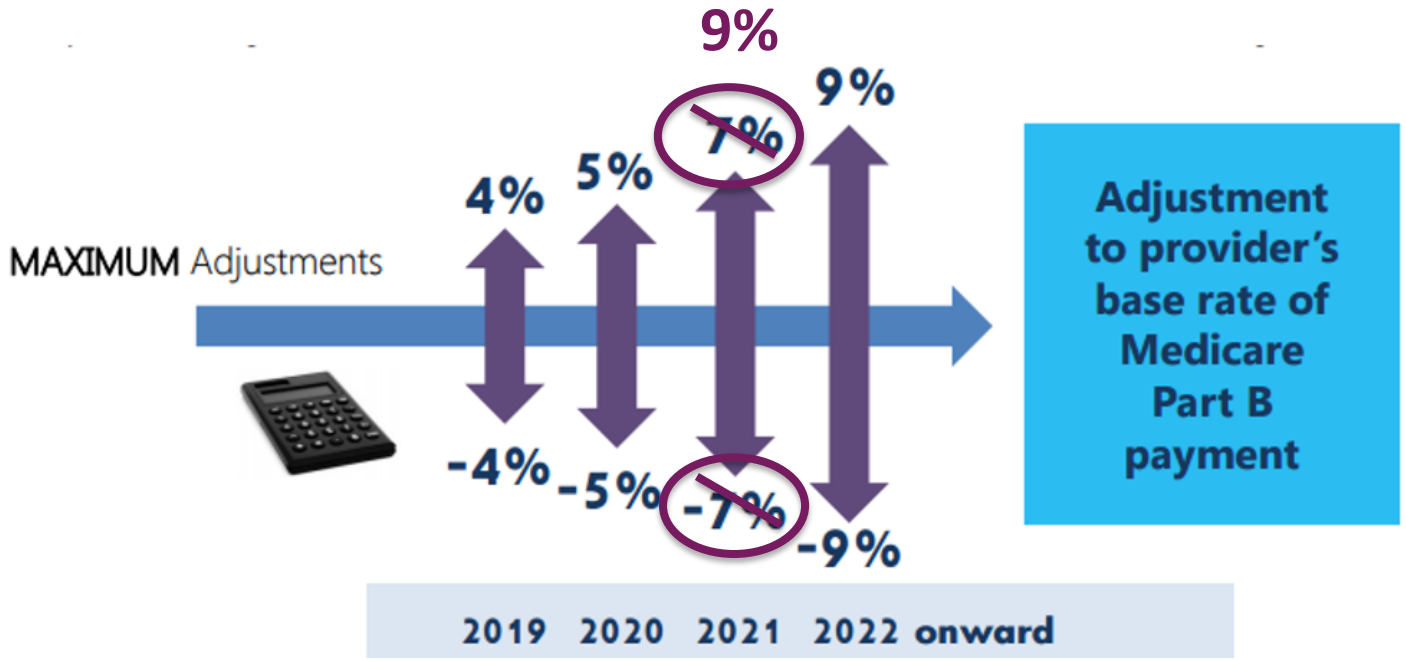
What About MACRA?

- Medicare Access and CHIP Reauthorization Act of 2015, or “MACRA”
- Created the current approach to Medicare physician payment and replaced the Sustainable Growth Rate with two new payment schemes:
  - **Merit-Based Incentive Payment System (MIPS):** administers bonuses or penalties based on how well providers perform relative to other providers on a set of quality and value measures
  - **Alternative Payment Model (APM):** offers bonuses and then provides higher annual fee updates than MIPS when physicians earn a sufficient amount of their revenue (or see a sufficient percentage of their patients) through qualifying Medicare or approved private payer payment models that require accepting financial risk if spending exceeds targets.

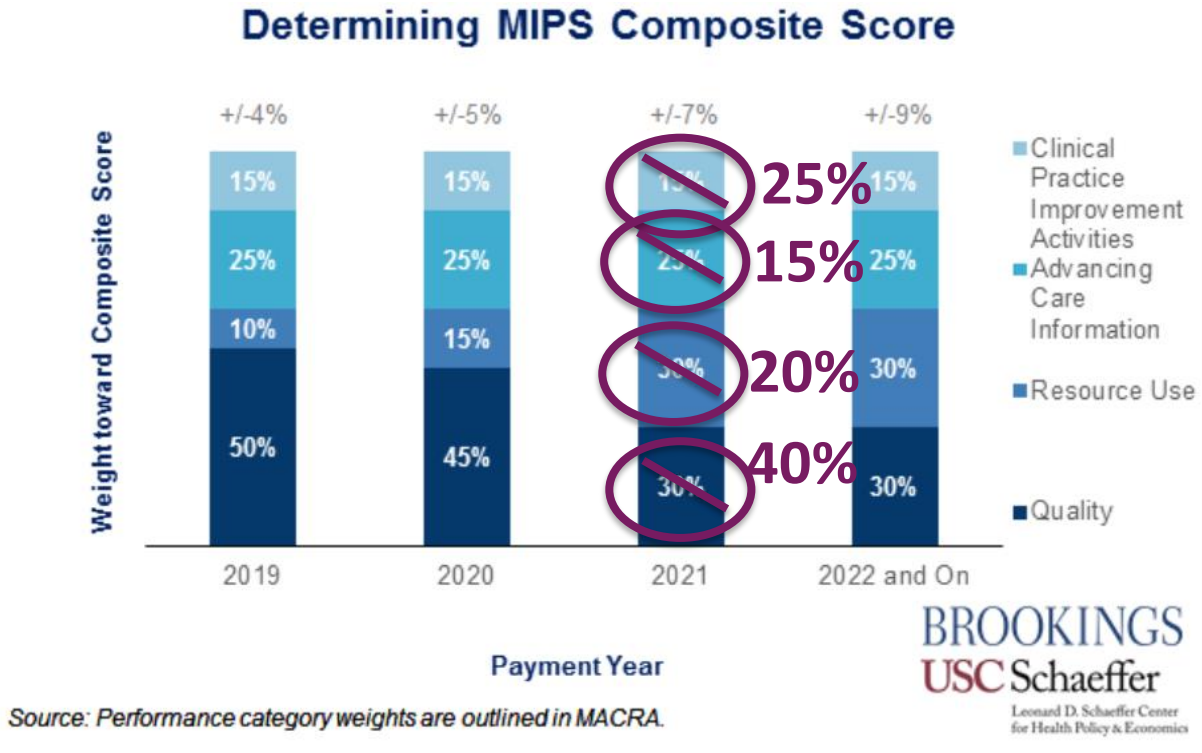
MIPS

- Merit-based Incentive Payment System
  - Scores clinicians based on their PERFORMANCE in 4 categories using a 100-point scoring system for the patients they see in a particular calendar year
  - CMS is increasing the minimum threshold to 60 points (up from 45 points in 2020) for the new performance year or be assessed a penalty.
  - "Exceptional" performance will remain the same at 85 points.
  - Maximum MIPS payment adjustments based on performance +/- 9%.
  - **Don't report MIPs in 2021? You will receive a -9% penalty to your Medicare Part B reimbursement**

https://mdinteractive.com/mips-blog/key-highlights-2021-final-mips-rule



https://www.brookings.edu/research/how-the-money-flows-under-macra/



https://www.brookings.edu/research/how-the-money-flows-under-macra/

Performance Category Weights	Performance Year 2021 Weight	Performance Year 2022 Weight
Quality	**40%** (from 45%)	**30%**
Cost	**20%** (from 15%)	**30%**
Promoting Interoperability	25% (no change)	25% (no change)
Improvement Activities	15% (no change)	15% (no change)

https://mdinteractive.com/mips-blog/key-highlights-2021-final-mips-rule

Medical Economics

Does value-based pay have a future?

September 18, 2019
Todd Shryock
Volume 96, Issue 18

- In the 2019 payment year (based on 2017 performance data):
  - 71 percent of MIPS participants received a positive payment adjustment with a bonus for performance
  - 22 percent received a positive payment without the bonus
  - 2 percent didn't receive a positive or negative adjustment and only 5 percent received a negative adjustment.
- Maximum payment adjustment: **1.88%**
- Maximum payment penalty: **5%**

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AJMC

Contributor: MACRA Has Not Lived Up to Its Promise

July 5, 2021

Travis Broome, MPH, MBA

- 2021 maximum increase MIPS: 1.86%
- 2018: nearly 98% of eligible clinicians had a positive MIPS adjustment

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JAMA Network Open

Original Investigation | Health Policy

Association Between the Physician Quality Score in the Merit-Based Incentive Payment System and Hospital Performance in Hospital Compare in the First Year of the Program

Laurent G. Glance, MD; Caroline P. Thirukumaran, MBBS, MHA, PhD; Changyong Feng, PhD; Stewart J. Lustik, MD, MBA; Andrew W. Dick, PhD

JAMA Network Open. 2021;4(8):e2118449. doi:10.1001/jamanetworkopen.2021.18449

- Looked at 38,000 specialty physicians from 2017 (first year of MIPS).
- When compared to hospital-wide measures of individual postoperative complications, readmissions, and failure to ***rescue few physician specialties had MIPS quality scores that resulted in better surgical outcomes.***

JAMA Network Open

August 3, 2021

The Merit-Based Incentive Payment System and Quality—Is There Value in the Emperor's New Clothes?

Richard P. Dutton, MD, MBA[1,2]

JAMA Netw Open. 2021;4(8):e2119334. doi:10.1001/jamanetworkopen.2021.19334

"CMS should rethink their pay-for-performance strategy for clinicians….As presently constructed, MIPS does little but contribute to the 34% of US health care dollars spent on administrative activities, with only marginal gains in quality improvement,"

Did Value Based Reimbursement Kill the Volume Zombie?

https://media.wired.com/photos/5a3d96ff7ed4041c061456d8/master/pass/l4d1.jpg

Did V sement
I ie?

NOPE.

https://c.stocksy.com/a/F9A300/z9/753997.jpg

Volume still matters.
A lot.

Why even talk about volume?

Because Health Care Systems are Still Fighting the Cold War.

https://www.buzzfeed.com/gabrielsanchez/28-iconic-pictures-that-defined-the-cold-war?utm_term=.bvNbmoAlO#.tnnGDBVlj

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The Market Forces a Focus on Volume

Health-care dilemma: 10,000 boomers retiring each day

Here's how millennials could change health care

Baby Boomers Will Become Sicker Seniors Than Earlier Generations

'We're the instant gratification generation.'

Forbes

Doctor Wait Times Soar 30% In Major U.S. Cities

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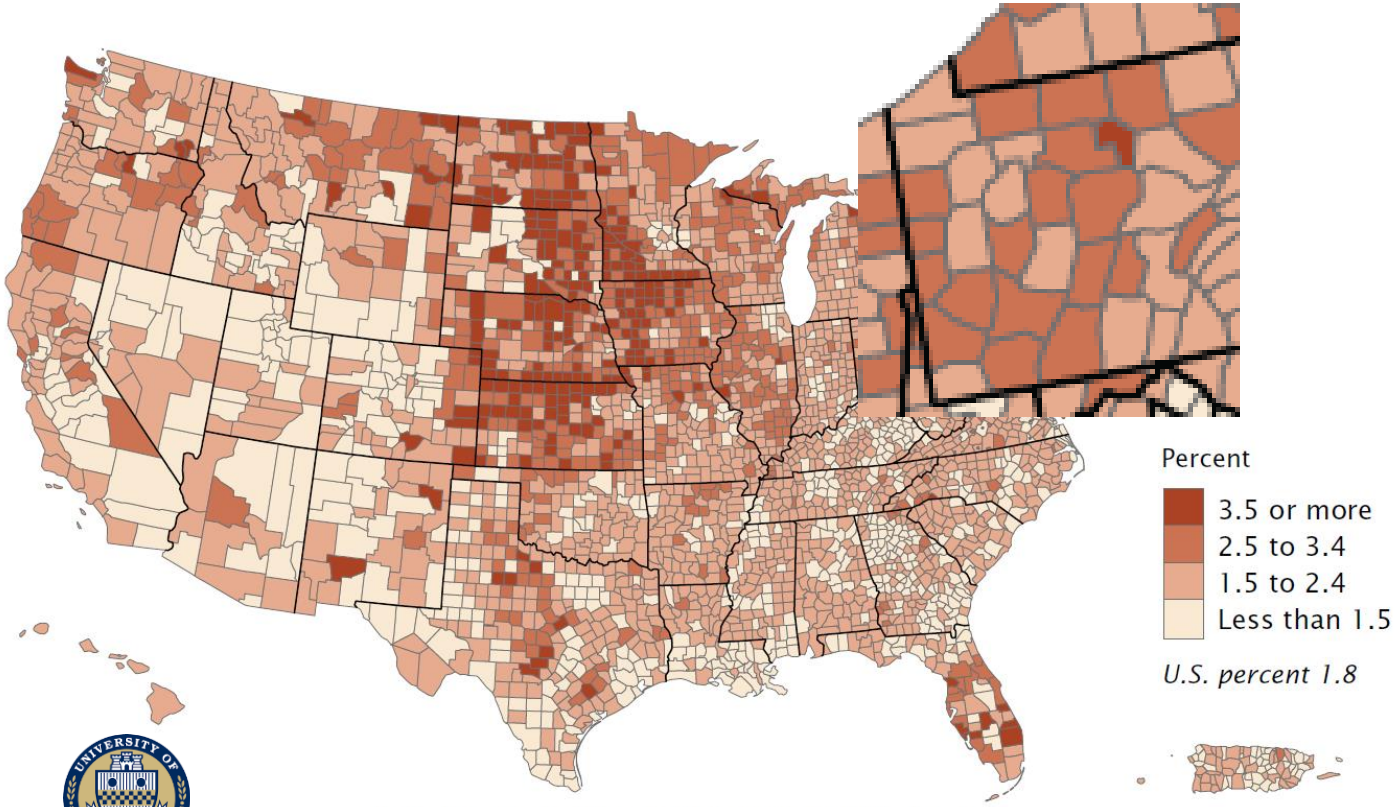
85 Years or Older



Source: U.S. Census Bureau, *2010 Census Summary File 1.*

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PennState Harrisburg | Pennsylvania State Data Center

RESEARCH BRIEF

Data Source: U.S. Census Bureau
2017 Small Area Health Insurance Estimates

Last Updated: 11/11/2019

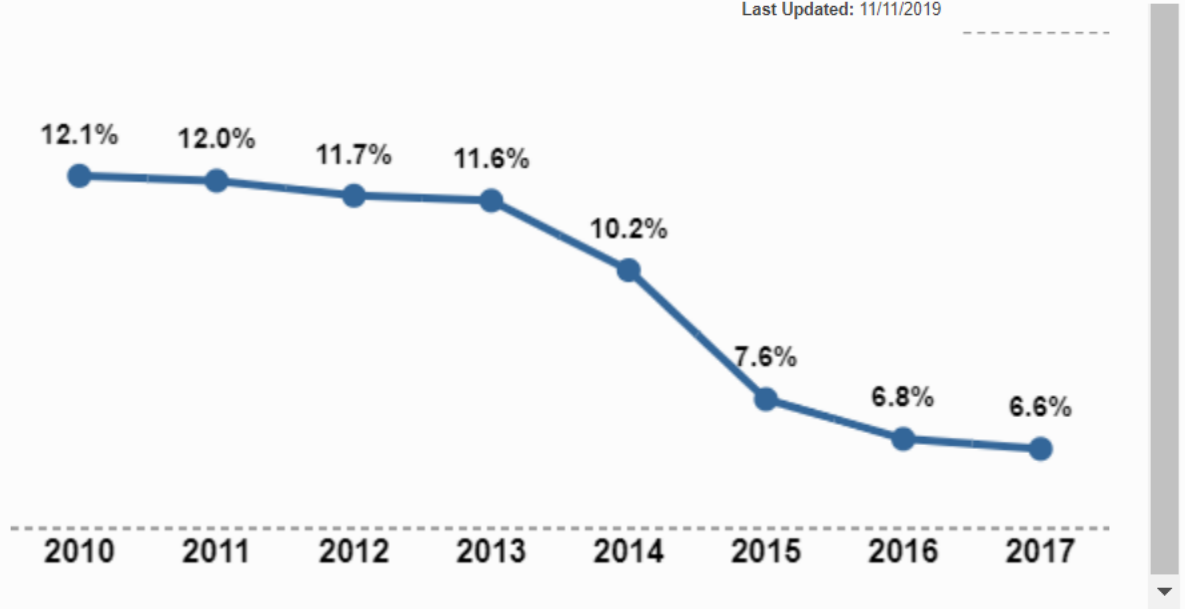

Figure 1. Percentage of Pennsylvanians lacking healthcare insurance coverage, 2010 to 2017.

By 2017, only 674,739 (6.6%) of Pennsylvanians remained uncovered.

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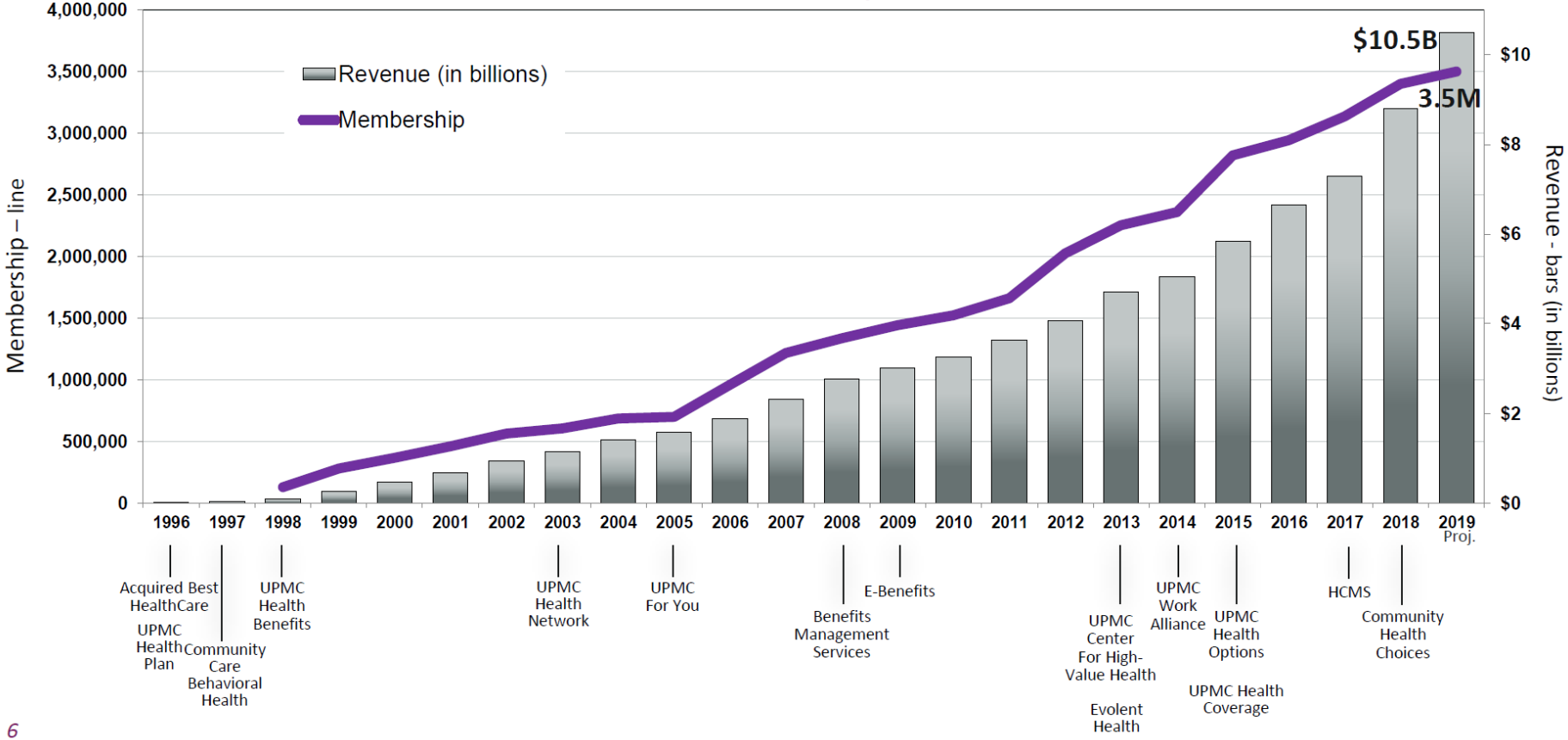
UPMC INSURANCE SERVICES GROWTH

2001 – 2019 … 12.0% Annual Growth in Membership; 16.4% Annual Growth in Revenue



Conclusions

- The country needed payment reform
- In the ten years since the ACA, more work needs to be done to achieve the right outcomes in value-based reimbursement models.
- VBR models have not replaced volume reimbursement.

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