Op-Ed

CMS, Demonstration Projects, and the Future of Value-Based Payments

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IN AUGUST, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) announced a proposed rule that eliminated or changed its mandatory bundled-payment models.¹ Although this change, at least directionally, had been widely anticipated, given Secretary Price's outspoken opposition to large-scale, mandatory demonstration models, there has been speculation as to whether this means a move away from a value-based care focus. That assumption confuses a reasonable opposition to what congressional Republicans saw as an attempt by the Obama administration to take over Congress's prerogative to legislate new Medicare reimbursement strategies. That's not the same as being opposed to using demonstration authority to try new payment methods.

There were several provisions in the proposed rule. The most important eliminated the Episode Payment Models and the Cardiac Rehabilitation incentive payment model. It reduced the number of geographical areas that were required to participate in the Comprehensive Care for Joint Replacement (CJR) model—from 67 to 34 metropolitan statistical areas (MSAs)—and made participation in the CJR model optional for low-volume and rural hospitals in the remaining 33 MSAs. This means 470 participating hospitals rather than the 800 that would have originally participated, and of these, about 60 to 80 will be participating voluntarily because they are low volume or rural. Hospitals in the 33 MSAs no longer required to participate can do so on a voluntary basis if they alert CMS by January 1, 2018.

Despite these changes, many physicians will want to continue participating in a bundled-payment model. As long as the model meets the requirements of an Advanced Alternative Payment Model (APM) included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the physicians will be eligible for a 5% bonus.

The American Medical Association supported the change, having previously expressed concern that the mandatory demonstration had

designated the hospital as the accountable entity for all services provided to Medicare patients, including physician services. The American Hospital Association (AHA) had been opposed to large mandatory programs because the known results didn't justify such a large-scale, aggressive move. However, the AHA expressed concern that cancellation might result in additional costs for hospitals preparing for the mandatory demonstrations.² Others have questioned whether the rule means that the move by CMS, and other payers, to value-based care has stopped.³

However, there are several reasons that the proposed rule is unlikely to represent a move away from value-based care. First, a majority of Republicans in the House were on record prior to the 2016 election as being against large-scale, mandatory demonstrations for reasons that had little to do with the substance of the demonstration. This is especially relevant when remembering that Congressmen Price (R-GA) and Burgess (R-TX) are two of the Republican physicians in the Congress who took leadership roles in getting MACRA passed. MACRA is the legislation that eliminated the much-hated resource-based relative value scale (RBRVS) sustainable growth rate (SGR) legislation that had been used to reimburse physicians under Medicare since the passage of the Balanced Budget Act of 1997. Unlike RBRVS, MACRA provides financial incentives for physicians either to join alternative payment organizations or to score well using the Merit-based Incentive Payment System (MIPS). While Secretary Price has been concerned about protecting small physician practices, especially rural practices, from undue administrative burdens, this is very different from being against the move to value-based care.

Second, while the cancellation of the mandatory demonstrations means that it will be harder to separate out the effects that result from the selection bias that is inherent in any voluntary demonstration (selection bias occurs because the physicians and hospitals that agree to participate in a demonstration may be systemically different from the average physician group or hospital), value-based payment demonstrations will continue. The Department of Health and Human Services (HHS) has also indicated an interest in considering new, clinician-originated demonstration projects. In addition, there are statistical techniques to adjust for some of the effects of selection bias before projecting findings to larger populations that include nonvoluntary participants. Indeed, Medicare has made many, in fact, most of its payment changes without the use of prior, large-scale demonstrations of any sort.

Third, while Medicare can have a large impact on what other payers do, the effects can go both directions. Private payers have been piloting projects that encouraged and provided incentives to patients and physicians and/or hospitals to choose providers who demonstrated greater value and efficiency, even before the Affordable Care Act (ACA). Accountable care organizations (ACOs) and similar organizations had been established by private payers before the ACA was passed into law. Legislation was needed so that Medicare could allow hospitals and physicians who weren't formally affiliated to share savings without running the risk of violating Medicare's antikickback provisions. Also, some private payers had been offering lower premiums or cost-sharing arrangements to patients who went to clinicians and hospitals that had been designated as preferred providers by the organization before the ACA, although the ACA focused more attention on value-based care.

The change in thinking at HHS about large-scale, mandatory demonstrations involving episode-based payments is also coming at a time when individuals knowledgeable about ongoing efforts to improve quality have been suggesting it may be time to rethink some of the programs that have been in use. Ashish Jha has expressed concern regarding the evidence coming from pay-for-performance (P4P) studies and also from the CMS value-based purchasing (VBP) efforts.⁴ Most of the studies of P4P have shown little effect on quality or patient outcomes. The studies evaluating VBP have been equally discouraging, including a comprehensive study published in 2016 that found no impact on patient outcomes from VBP after 3 years.

Jha emphasizes using incentives that are large enough to motivate institutions to make the investments that can improve care, relying on a small number of high-value measures that motivate clinicians to make changes in how they practice, and using a design that is simple enough to let clinical and institutional leaders know how they are doing.

Chip Kahn has raised similar concerns about whether the CMS efforts have become too much of an exercise in mandated compliance rather than a means of improving performance.⁵ He suggests targeting measurements that minimize administrative burdens and help an institution become a delivery system focused on clinically integrating care.

The need to refocus, simplify, and change the incentives being used to determine the P4P and VBP that both Jha and Kahn have discussed is consistent with the changes being introduced by HHS. Getting it right—or at least improved—on the next round

of demonstration projects will remain a challenge. Getting rid of mandatory demonstrations does not preclude this refocus.

References

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