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Medicare's 'dramatic change' in how it pays for care

With much fanfare, U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced in late January that Medicare would dramatically change how it pays for services, "setting clear goals—and establishing a clear timeline—for moving from volume to value in Medicare payments."[a]

Medicare has been attempting to improve the incentives used in its payment systems since DRGs were introduced in the early 1980s, when the program moved from a per diem payment for hospitals to a fixed payment at discharge. However, Secretary Burwell's announcement reflects a more sweeping attempt to change all parts of Medicare payment, rather than focus on only one type of payment at a time.

Current Medicare Payment Approaches

Medicare already uses a system of bundled payments for hospital services (both inpatient and outpatient care), with a hospital receiving a fixed payment per admission to cover the various services it provides during a patient stay, episode payments for home care, and all-in per diem payments for nursing homes. These payments encourage efficiency for services provided within the bundle, but do not reward the provider for reductions in the total cost of care or for high-quality or improved health outcomes. Physician payment remains on a fee-for-service basis using the highly disaggregated relative-value scale combined with a spending limit. As a result, physician payments, more than other areas of Medicare, reward volume and disregard the effects of physician services on quality or health outcomes.

The Affordable Care Act (ACA) set forth provisions calling for value-based purchasing programs for hospitals, nursing homes, and home care, involving bonuses that may seem relatively small to higher-value institutions and a "value modifier" for physician payments, which begins in 2015 for larger practices. The ACA also allowed for the creation of accountable care organizations (ACOs) and the implementation of a variety of pilot projects aimed at promoting value and better-coordinated care, including bundled payments that encompass all services a patient receives from all providers during an episode of care; patient-centered medical homes (PCMHs); and various other primary care initiatives.

The effects of these strategies have been mixed, and in general, positive results have been limited. ACOs have generally realized improvements in quality measures, but have found it more challenging to achieve savings. Among the first 220 ACOs participating in the Medicare Shared Savings Program (MSSP), only about 25 percent reduced costs enough to share savings with the government.[b] Most of these ACOs also engaged only in "upside risk"—sharing savings but not sharing losses, even though the shared savings are much higher for plans that are willing to take on downside risk. In December, CMS released a rule that allows ACOs to accept only upside risk for up to six years instead of for the initial limit of

a. See Secretary Burwell's blog post, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," Jan. 26, 2015.

b. See Centers for Medicare & Medicaid Services, "Fact Sheets: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth," press release, Nov. 7, 2014.

three years. Among the ACOs in Medicare's Pioneer ACO model, in which participating organizations have greater experience with care coordination across settings and agree to engage in both upside and downside risk, almost one-third have dropped out, with many of them opting to join the less financially risky MSSP.

Savings from PCMHs have been reported more frequently by groups involved in the activity than by independent evaluators, raising questions about the credibility of the reports attesting to savings. The few independent evaluations that have been performed have generally indicated no savings or very small savings relative to the costs of adding extra staff, IT, and call lines. A recently reported evaluation by Mathematica Policy Research of primary care innovations indicated CMS paid $20 per beneficiary to save $14 per beneficiary.[c]

Proposed Changes in Medicare Payment

HHS has proposed that Medicare make a significant move away from fee-for-service payments over the next several years. Currently, alternative payment structures of any sort represent about 20 percent of Medicare payments. Secretary Burwell has proposed that 30 percent of traditional fee-for-service payments be shifted to some sort of alternative payment structure by the end of 2016, with the proportion increasing to 50 percent by the end of 2018.

Among the many challenges that HHS will face in translating these goals into practice will be determining which alternative delivery systems should count as improving value and which quality metrics healthcare organizations should be required to provide as part of the process.

When the ACO rule was first proposed, HHS suggested requiring organizations to provide 66 quality measures to qualify for a share of the savings produced. This list ultimately was reduced to 33 metrics. The problem for many healthcare organizations and physician practices is the lack of agreement across the many payers their patients use about what constitutes appropriate metrics. The National Quality Forum recently released recommendations regarding a list of some 200 possible metrics.[d] There also is increased interest in looking at measures about improved patient performance and functioning.

The private sector also has expressed interest in increasing the use of incentive payments for improved quality and reduced cost. Private payers have already been actively developing PCMHs, entering into multipayer primary care initiatives, and encouraging the use of selected clinicians and institutions identified as low-cost, high-quality providers.

Several of the largest payers recently announced their intent to collaborate in a new task force designed to shift 75 percent of their business to contracts that have incentives for quality and cost by 2020.[e]

Challenges Ahead

It is hard to argue directionally with the changes being proposed by both Medicare and the private sector. The nation's historically high levels of spending on health care are generally attributed to the longstanding incentives for providers to deliver increasing amounts of complex care, with minimal reward for those providers that deliver higher-quality care at lower cost. The past decade—and in some ways, the past several decades in Medicare—included many attempts to move to different payment strategies, with only minimal success in addressing this core problem.

The impact of current reform strategies is difficult to assess, but as these strategies and their required metrics and standards have proliferated, they have begun to produce their own challenges and disincentives. Many physicians express frustration with the multiple metrics they have to

c. "CMS Reports Mixed Results for First Year Of Primary Care Initiatives," Inside Health Policy, Jan. 23, 2015.

d. See National Quality Forum, "Process and Approach for MAP Pre-Rulemaking Deliberations 2015," January 2015.

e. See Health Care Transformation Task Force, "Major Health Care Players Unite to Accelerate Transformation of U.S. Health Care System," press release, Jan. 28, 2015.

report depending on their patients' insurance plans, for example. Nonetheless, the provider community is increasingly recognizing that improved coordination and better, prompter data sharing are essential to support efforts to improve performance.

Perhaps even more challenging is the need to define more clearly the degree to which payment should be focused on rewarding value or improved health outcomes to produce the desired changes. Currently, the amount of payment that varies with "value" is extremely small. Medicare's Hospital Value-Based Purchasing program, for example, withholds only 1.5 percent of the DRG amount from payment to hospitals to fund incentive payments for participating hospitals, and the amount withheld will increase to only 1.75 percent in FY16 and to 2 percent in FY17.

The value modifier for physicians is more complicated, but in 2015, groups of 100 or more eligible professionals are subject to a downward adjustment of 1 percent if they do not satisfy participation and reporting criteria in the Physician Quality Reporting System or are not involved in an alternative payment model.

Whether these small adjustments to payments will have the desired impact on behavior is unclear, but they clearly do not square with Secretary Burrell's asserted goal of having 30 to 50 percent of payments tied to value by the end of 2016. It will be interesting to see whether what's being contemplated will affect provider behavior. ■

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