

# Value-Based Purchasing in Medicare

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Meeting on Making Medicare Sustainable, sponsored  
by the New America Foundation and the Urban  
Institute

July 23, 2008

# Today's Talk

- underlying assumptions
- goals for Medicare as a VBP
- actions toward value-based purchasing
- concluding notes

“We should recognize that the scientific side of medicine is up to date and in full synchronization with the peaks of human achievement, while . . . the social and the economic sides as developed are often archaic and ineffective in operation.”

“The High Points in the Recommendations of the Committee on the Costs of Medical Care,” by Ray Lyman Wilbur, *Journal of the American Medical Association*, vol 207, #24, **1932**.



*"I see by your copy of 'Newsweek' that Lyndon Johnson has decided not to run for reelection."*



*"Doctor, you must stop addressing your Medicare patients as Comrade."*

# Assumptions (1)

- THERE IS NO MAGIC BULLET, NO PANACEA.

## Assumptions (II)

- need: MDs and hospitals to develop organized processes to improve quality and control costs
- these processes will be developed if Medicare rewards provider organizations that provide cost-effective, high quality care

# Assumptions (III)

- fragmented delivery system:
  - lack economies of scale to implement organized processes
  - lack of coordination among physicians and between physicians and hospitals (and other parts of the delivery system)

# Nine Goals

- Most are obvious (e.g. improve the quality and control the costs of care)
- In this talk I highlight four of the nine goals

# Selected Goals

- Encourage innovation in:
  - the use of organized processes by providers
  - the organization of the delivery system
- Maintain beneficiary choice of providers
- Do not pick winners and losers within the delivery system
- Decrease or at a minimum do not increase racial/ethnic/economic disparities in the care provided to beneficiaries

## Selected Actions (of the 20)

- maintain a census of U.S. physicians, medical groups, and accountable care systems
- require physicians to meet higher standards as a condition of participating for providing certain services - notably imaging, surgical, and endoscopic procedures - in their offices

## Selected Actions (II)

- Exclude individual hospitals from Medicare if they failed to meet minimum quality standards for four years in a row
- Encourage, but not require, beneficiaries to choose a practice as their medical home

# Medical Homes

- the medical home would be the practice (or the Accountable Care System), not the individual physician
- medical home patients would be able to see physicians outside their medical home without a referral

# Accountable Care Systems

- To be defined as an ACS, an organization must:
  - be willing to take responsibility for the overall costs and quality of care for a population of patients
  - have the size and scope to fulfill this responsibility
  - be accredited as a medical home.

# Possible Types of ACS

- integrated system (e.g. Kaiser, Geisinger)
- “virtual organization (e.g. IPA, PHO)
- large medical group
- large hospital or hospital system with employed physicians
- might or might not include rehab hospitals, LTC facilities, etc.

## ACS Held Responsible for the Population of Patients Who

- choose the ACS as their medical home for  $\geq 7$  months in a year
- have not chosen the ACS, but receive most of their care there, as retroactively assigned by Medicare

# Payment Methods and Public Reporting for Hospitals

	DRG-based Payment	Quality Bonus	Patient Experience Bonus	Payment for Avoidable Complications	Public Reporting
Not part of an ACS	National annual update	Based on the hospital's inpatient and outpatient care	Based on patients' experience with the hospital	Denied	Based on hospital quality and patient experience
Part of an ACS	Annual update specific to that ACS	Based on the quality of care received by the ACS's patients (even when received outside the ACS)	Same as above	Paid	Same as above

# Payment Methods and Public Reporting for Physicians

	Cognitive Services	Preventive Services	Procedures	Quality Bonus	Patient Experience Bonus	Public Reporting of Quality	Public Reporting of Patient Experience
Not member of ACS or medical home	fee-for-service with national annual update			?*	based on the individual MD**	No	based on the individual MD
Member of med home; not of ACS	discounted ffs plus med home payment; national annual update***	Same as in the row above					
ACS member (also med home practice)	as in the cell above, except annual update specific to that ACS	same as in the rows above, except annual update would be specific to that ACS	quality of care received by the ACS's patients, wherever they received it	same as in the rows above	ACS quality would be reported	based on the individual MD	
<p>*Small amounts would be paid to individual physicians to the extent that reliable and valid risk-adjusted measurement can be done</p> <p>** Would include questions about the practice, if any, of which the physician is a member.</p> <p>***Reimbursement for non-medical home patients would be at the full fee-for-service rate.</p>							

## Selected Actions (III)

- Medicare would not make additional payments for such things as care coordination or e-mail or phone communication with patients
- Medicare incentive programs would incorporate:
  - design features explicitly intended to minimize or eliminate undesirable consequences
  - incorporate ongoing evaluation explicitly intended to identify them if they occur
- CMS should receive adequate funding to carry out the activities necessary to VBP

# Feasible?

- actions are technically difficult, but feasible
- legal changes would be necessary for many of the actions
- politically, challenges would be enormous

# Desirable?

- retains patient choice of provider and provider choice of practice setting
- rewards high performance and innovation
- relatively simple to understand
- actions synergistic
- balances quality and cost incentives
- at a minimum, would control costs
- difficult to believe that would not improve quality

# Pilots and Demos: Pro

- making major changes without evidence could easily do more harm than good
- the Medicare Health Support results

## Pilots and Demos: Con - They Can be “Artificial”

- do not include full range of balancing incentives - testing one action in isolation not a valid test
- providers and patients must deal with the rest of the delivery system, which is doing business as usual
- providers know program may be temporary; participating providers likely to underinvest
- insufficient time for patients and providers to become familiar with the concept