The Economist Intelligence Unit

A case study from The Economist Intelligence Unit

Case study

US healthcare is notoriously fragmented and complex, but value-based care has thrived in some areas. Policies being developed by the Centers for Medicare and Medicaid Services (CMS) now aim to replicate and spread good practices and shift the trajectory of US healthcare away from fee for service models and towards value-based care.

Putting value in place: America's CMS Innovation Center

Value-based care plays a small role in US healthcare, but pockets of value-based innovations are emerging across the system. The Centers for Medicare and Medicaid Services (CMS), the federal agency that funds public programmes for older people and the underprivileged, is driving much of the change.

The CMS is a governmental body covering 100m citizens, and because of the large population to which it caters, its influence on the industry is substantial. When the CMS pushes for an adjustment in delivery of care and payment models, providers begin to put new systems in place, making it easier for payers in the private sector to ask for the same thing, says Jeffrey Selberg, chairman of the Peterson Center on Healthcare. "The old adage here is that when CMS catches a cold the rest of the system gets pneumonia—meaning they have a huge influence," he says.

In November 2010, the Affordable Care Act (ACA) established the CMS Innovation Center, with an initial budget of $10b over 10 years and the remit to test payment, service and delivery models that would deliver higher quality of care *and* reduce costs. The Innovation Center now funds seven types of innovation models, promoting value-based care—ranging from accountable care to episode-based payment initiatives to projects aiming to speed the adoption of best practices. The projects start out as smaller pilots, and those that show evidence of success are rolled out across the system.

Dr Patrick Conway, a practising physician, is Deputy Administrator for Innovation & Quality, CMS Chief Medical Officer, and leads the Center for Medicare and Medicaid Innovation. "Value-based care is central to all the work that we do," he says. "The heart of the issue is we are

Commissioned by Medtronic

attempting to help transition the US health system from one that pays for volume or fee-for-service to one that pays for value."

To execute efficiently and move in the right direction, clarity is key.

More accountable care

The Innovation Center funds dozens of models (each falling under one of the seven headings mentioned above), designed to improve a different aspect of care. Under the category of "Initiatives to Speed the Adoption of Best Practices" falls Partnerships for Patients, a public-private partnership with the goals of working with hospitals to decrease the number of conditions, such as infections, patients acquire at hospitals; and engaging families and reaching out to community based care organisations to smooth transitions as patients leave hospital to heal. Another model, the "Bundled Payments for Care Improvement Initiative" lays out alternative ways that payments would cover hospital stays for acute illnesses.

"Value-based care is central to all the work that we do. The heart of the issue is we are attempting to help transition the US health system from one that pays for volume or fee-for-service to one that pays for value."

Dr Patrick Conway, Deputy Administrator for Innovation & Quality, CMS Chief Medical Officer, and leads the Center for Medicare and Medicaid Innovation.

Perhaps the best known Innovation Center programme is the Pioneer Accountable Care Organizations programme, a system that builds alternative payment models onto a fee-for-service structure. The goal is to provide coordinated care that keeps patients well rather than treating illness. If the provider delivers a high quality of care at a lower cost and makes savings for the Medicare programme, it will share in those savings.

The Innovation Center launched the project in 2012 and because it was shown to have good results it was then rolled out more widely. "Pioneer ACO was certified for expansion, and we now have an ACO in every state," Conway says. "It is a programme with 8 million beneficiaries approximately—a very large programme."

Joined-up care in Michigan

Michigan Pioneer ACO is one such organisation. Responsible for a population that the CMS selected from the local Medicare population, it is accountable for the cost and quality of outcomes of that group. Doctors and even some non-physician staff receive incentives for meeting the programme's criteria. There are additional incentives for the effective use of electronic health records, with the explicit goal of making medical records more accurate and easily accessible.

At Michigan Pioneer ACO, the clinicians' oversight of their patients' health extends beyond the immediate confines of their visit to the consulting room. In a video testimonial on the ACO's website, one woman describes how she was able to call a nurse in the middle of the night via 24-hour number when she fell ill. In subsequent home visits the nurse explained the role of each medication the patient was taking and ensured that she took each one appropriately by checking in with her regularly.

Scope for improvement

In an ACO, patients opt in to the programme and are not locked in. Once they have agreed to participate their outcomes become part of the provider's results. The voluntary aspect of the patient's role (or "attribution") is crucial, Conway explains. "We think the beneficiary choice—for us in the US, probably not that surprisingly—is a fundamental principle."

Some observers have criticised this aspect of ACOs for not going far enough. For Jeffrey Selberg, chairman of the Peterson Center on Healthcare, ACOs mark a half-way point towards full provider responsibility (or capitation) for a patient population. His opinion of ACOs is mixed. Adjustments to reimbursements are not themselves enough, says Selberg, whose organisation, the Peterson Center, works to highlight and help replicate exemplary operations. "The issue that we see is that along with the shift in payment, needs to be a shift in practice."

There have been other criticisms too. In 2015 Dartmouth-Hitchcock Medical Center withdrew from the Pioneer ACO initiative, complaining that because it had run efficiently before it entered the ACO programme, it was penalised by excessive standards that were set, and could not make further savings and lost money as a result. Indeed the drop-out rate is high, with 13 ACOs leaving the Pioneer programme after the first year. The very fact of patients' freedom, while it incentivises providers to keep them in the system, can also put the ACOs finances at risk if too many choose to get their care elsewhere.

Broadly, the initial financial results for ACOs have been positive: Pioneer ACOs generated $120 m of savings in their third year. But in an article in the Journal of the American Medical Association in June 2015, Conway and several co-authors knowledged that it might take more time for some ACOs to redesign care delivery and learn how to manage populations. In addition, they wrote, "CMS may also need to re-examine specific design elements to facilitate better performance, such as expenditure benchmarking methodologies that are more predictable to the ACO or enhanced benefits and other tools to engage beneficiaries."

A learning model

"When we launch a model we always say we know we're going to learn and change this model along the way. That's a foundational principle."

Dr Patrick Conway,

More broadly, the CMS has laid out a range of goals for altering its payment incentives and has been meeting some of them ahead of time. A target of tying 30% of Medicare payments to quality by end of 2016 was reached earlier this year. Conway attributes this to the positive impact of the Center's programmes.

At the Innovation Center, continuous evaluation and learning are central principles, and if a project doesn't improve value or lower costs, it is brought to an end. Each initiative is evaluated on a quarterly basis by an external team the government contracts independently. Conway describes the process as evidence-based rapid-cycle evaluation. "When we launch a model we always say we know we're going to learn and change this model along the way," he says. "That's a foundational principle. I am trying to think of any model that *didn't* change along the way and none is jumping to mind."

Furthermore, establishing goals for moving towards value-based care has had a further knock-on effect. "Setting goals created a path of showing where we think we're going as a nation," he suggests. "Increasingly we're seeing providers stepping forward to volunteer to move towards these kinds of payment models."

Volunteerism is clearly one challenge the CMS and its Innovation Center face going forward. The next step is to impose certain Medicare and Medicaid payment strategies without offering alternatives. "Now we're trying to think through—if you've picked up the leading edge 30%, how do you pick up the next 30 to 40%? Does that look different in some ways?" Conway says.

As for the future roleof value-based care within the government agency, it has already been clear, outlined in a timeline the CMS published in 2015. By 2018 the goal is for 50% of Medicare payments to reward alternative models (ie. not fee-for-service) and tying 90% of payments to quality or value—an achievement Conway says would represent tipping point.

In the meantime, "certainly we could improve", he notes. "We could always learn and move faster. But I think the overall level of improvement for physicians and patients is significant." ■