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What's Ahead for Value-Based Health Care?

Prior to the presidential election in November, experts believed that the trend toward value-based payment – the concept of rewarding providers based on the quality of care delivered, rather than the number of procedures performed – would continue to grow. The election of President Trump, the Republicans' assumption of control of both houses of Congress, and the anticipated repeal of the Patient Protection and Affordable Care Act (the "ACA"), however, have raised questions from the health care industry about what changes to expect in value-based health care going forward.

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Value-based health care has been widely perceived to be an effective method to reduce health care costs. Over the past five years, the Center for Medicare & Medicaid Innovation ("CMMI") at the Centers for Medicare & Medicaid Services ("CMS"), which was established as part of the ACA, has begun several demonstration projects nationwide to test various value-based payment models and been the industry leader in transitioning toward payment for value. Health care organizations in the state and private sectors have also begun to experiment with varying ways of incentivizing providers to "bend the cost curve" to provide higher-quality, lower-cost care to patients.

President Trump and Congressional Republicans are working to repeal and replace the ACA, although the timing of any repeal currently is unclear. As Congressional Republicans do not have a sufficient majority in the U.S. Senate to complete a full legislative repeal of the ACA, Republicans will likely use a tactic referred to as budget reconciliation to effect a repeal. Budget reconciliation is a Congressional budgetary process to change existing law to bring spending into conformity with the budget. Because budget reconciliation requires compliance with Congressional budget rules, however, there are limitations to what elements of the ACA the President and his Republican allies can affect through budget reconciliation. It is unclear whether CMMI could be repealed or defunded through budget reconciliation. To the extent CMMI is not repealed or defunded, it will continue to exist as a division of CMS, and the Secretary of U.S. Health and Human Services ("HHS") will continue to have broad authority over the types of programs that are tested through CMMI, the termination or alteration of current programs, and the development of new programs. Thus, value-based health care programs will be affected not only by repeal of the ACA, but also in large part by the discretion of the HHS Secretary. HHS Secretary Tom Price has been a vocal opponent of certain value-based payment models and his views are critical to considering how value-based health care could be reshaped under the new administration.

The President and Congressional Republicans intend to replace the ACA with another form of health care legislation. At this point, there is not consensus on what elements a replacement bill would include nor is there clarity on the timing of the passage of any replacement bill (any replacement bill would require 60 votes in the U.S. Senate). Changes to federal health care policy contained in an ACA replacement bill, such as funding the Medicaid program through block grants, could also affect value-based purchasing at the federal and state levels. Repeal of the ACA may influence the used of value-based payment in the private sector as well.

This paper considers how the new leadership at HHS, and any repeal and replacement of the ACA, could reshape value-based payment testing models at CMMI and value-based payment across the health care industry.

CMMI Under the New Administration

As discussed above, CMS, through CMMI, has been a leader in proposing and testing value-based payment models. The HHS Secretary has broad authority over CMMI. Thus, the views of HHS Secretary Tom Price are instructive to better understand how value-based payment under CMMI could be reshaped under the new administration.

Tom Price is an orthopedic surgeon and former Republican Congressman from Georgia who served as the Chairman of the House Budget Committee and as a member of the health subcommittee of the House Ways and Means Committee. Price has been a long-standing advocate for physicians and, in particular, opposes what he perceives to be government interference in the doctor/patient relationship. Price has also been a critic of the ACA and was one of the first Republicans to propose his own replacement plan, the [Empowering Patients First Act](#) (the “EPFA”). The latest version of the EPFA would repeal the ACA in its entirety, including all value-based initiatives, and replace the ACA with a free-market approach that offers less coverage for and fewer protections to consumers. Price’s plan calls for significant changes to the insurance market in the United States through insurance market deregulation and individual incentives (e.g., allowing plans to be sold across state lines and offering age-based tax credits to consumers). The EPFA would also increase legal protections for providers by exempting providers from Federal antitrust laws when negotiating with health plans and providing protection from costly malpractice suits through the use of health care tribunals.

Price has also criticized CMMI on multiple occasions. As a general matter, Price believes that CMMI models should be limited in size and scope and established through an “open, transparent process that supports clear and consistent communication with physicians, patients and other relevant stakeholders.” Thus, CMMI activities under Price will likely be limited and include involvement from providers.

Price has also opposed mandatory value-based payment models, such as the Comprehensive Care for Joint Replacement (“CJR”) Model. Under these mandatory models, providers are selected by CMS at random to participate in a payment model and must participate to receive CMS funding. Price previously proposed [legislation](#) suspending implementation of the CJR Model, and authored a [letter to CMS](#) demanding that CMMI cease “all current and future planned mandatory initiatives.”

Given Price’s vocal opposition to mandatory payment models, it appears likely that Price will move to terminate or phase out mandatory value-based payment models such as the CJR Model. Phasing out mandatory payment models entirely would present a variety of questions for the health care industry. For example, providers may need to consider whether care delivery management agreements related to such mandatory programs are terminable. Medical device companies and other providers that provide care management services focused on mandatory payment models may need to adapt to the changed environment, possibly through renegotiating agreements or evolving into management agreements focused on private value-based payment contracts.

Other voluntary value-based payment models, such as accountable care organizations (“ACOs”) and the bundled payments for care improvement (“BPCI”) initiative, which enjoy bipartisan support, are likely to remain in place in some form. Given Price’s historic opposition to administrative burdens on providers, however, it is possible that regulations related to such programs, such as reporting requirements, may be altered or limited.

As value-based payment generally has bipartisan support as a method to contain health care costs, it appears likely that CMS will continue to develop new value-based payment models, although such models will likely be limited in size and scope, and participation by providers would likely be voluntary. The HHS Secretary has discretion to test CMMI models so long as the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures and the models are expected to reduce program costs while preserving or enhancing the quality of care received by individuals receiving benefits. It remains to be seen what types of programs the new administration would seek to develop and test.

Other Considerations for Value-Based Health Care

Collateral Effects Under MACRA of Elimination of Value-Based Payment Models

A rollback of certain CMMI programs could have additional impacts on physician payments under The Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). MACRA repealed the Medicare Sustainable Growth Rate formula and replaced it with two Quality Payment Program tracks for physicians: the Merit-based Incentive Payment System (“MIPS”) and the Advanced Alternative Payment Models (“APMs”).

Under MACRA, APMs include certain CMS-administered value-based payment programs or federal demonstration projects. Although MACRA enjoyed broad bipartisan support and is unlikely to be altered by Republicans in the new administration, MACRA could be undermined if CMMI value-based programs, such as the CJR Model, are eliminated or reduced because providers would be unable to participate in APMs, which qualify providers for full fee schedule increases under MACRA. Currently, approximately 5 to 8% of all Medicare clinicians in 2017 would be eligible to participate in APMs; however, CMS expected this percentage to grow as providers were incentivized to participate in value-based programs to qualify for increased reimbursement. If these value-based programs are repealed or curtailed, however, fewer providers would qualify for APMs.

Changes to Medicaid May Impact Use of Value-Based Payments by States

The President and Congressional Republicans intend to repeal the ACA’s Medicaid expansion in favor of providing states with Medicaid block grants, referred to as “State Flexibility Funds.” A shift to Medicaid block grants would decrease the amount of federal Medicaid funding to the states. It is possible that, in response to decreased federal funding, some states may cut services and beneficiary eligibility or apply for, and receive, Medicaid waivers from CMS that increase cost-sharing for Medicaid beneficiaries to close budget gaps. Seema Verma, the President’s selection for CMS Administrator, is a Medicaid consultant with extensive experience obtaining state Medicaid waivers. Verma designed the Indiana, Ohio, Iowa and Kentucky Medicaid waiver applications, which emphasize personal responsibility in the Medicaid program. Under Verma, CMS would likely approve state Medicaid waivers such as those that impose additional eligibility requirements such as work requirements (as in Kentucky) and beneficiary cost-sharing (as in Indiana).

It is also possible that, particularly for states that are hesitant to cut beneficiary benefits, a decrease in federal funding for the Medicaid program could drive increased use of value-based payment at the state level as a method of controlling costs.

Value-Based Payment Is Here to Stay

As federal value-based payment models have led the way in transitioning health care delivery system toward a system of payment for quality, the new administration creates uncertainty in the industry regarding value-based payment. Given the importance of cost containment in health care and the widely perceived view that value-based health care is key to health care cost control, however, value-based health care will likely continue to expand in some form.

At the federal level, the ACO and BPCI programs will likely remain in place, and CMS will likely begin to develop more limited, voluntary value-based payment programs.

Many players in the private sector are also charging ahead with value-based health care. On January 25, 2017, several providers, payors, pharmaceutical companies and consumer groups declared their continued support of value-based health care and urged the President to build on and expand value-based payment models. Private payors are continuing to develop new value-based payment models with providers and pharmaceutical companies. In response, providers are continuing to invest in care delivery management infrastructure, such as information technology and related support, and continuing to consolidate in an effort to better control costs in a value-based health care environment.