The U.S. Medicare Program's Quest to Obtain Value for Money Spent: Tying Case-Mix Payments to Performance, Quality, and Efficiency

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Introduction
The United States, Secretary of the Department of Health and Human Services, made it very clear in January 2015 that by the end of 2018, more than 90% of all Medicare payments will be tied to quality and alternate payment models. To achieve this, there are a myriad of initiatives underway in the U.S. today to incent hospitals and physicians to provide high quality, low cost health care services to patients without any compromise in outcomes. The Medicare program is investigating new payment initiatives in search of finding what it calls, "Alternate Payment Models" (APMs) to use in all different care settings (inpatient, outpatient/ambulatory, day surgery etc. for both facility and physician reimbursement). Some of these are already under-way as pilot projects. For example, there are bundled care payment initiatives (BPCI) underway aimed at testing new ways that Medicare can pay for larger bundles of services. There are new episode initiatives also being introduced daily, such as the recent proposed rule on new hip and knee replacement episodes of care.

Other initiatives are already underway where a larger and larger percentage of hospital's total reimbursement from MS-DRGs for example is placed at risk if hospitals do not achieve or exceed a number of different performance thresholds. These initiatives increase or decrease the case-mix level payment a hospital receives based on performance. All of the initiatives underway or those being evaluated for implementation aim to advance the concept of having larger and larger bundles of services that are paid at a single rate - such as an episode of care payment or a flat rate for integrating care across sites of service. For now, many of these larger bundles consist of services often described by different case-mix/classification groupings, but over time this is likely to change.

Methods
In this section, current and future methods being used and/or pilot tested by the Medicare program in the near future (2016-2018) will be highlighted. These include but are not limited to the following:

* Quality Measures Being Collected
* Payment Reductions for Poor Performing Hospitals on Hospital-Acquired Conditions
* Payment Reductions for Excess Hospital Re-Admissions
* New Comprehensive Joint Bundle Payment Initiative for Elective Hip and Knee Replacements
* Value-Based Purchasing
* Bundled Care Payment Initiatives & Alternate Payment Models Being Studied by the Center for Medicare and Medicaid Innovation (CMMI)

All of the initiatives that will be presented are aimed at moving the traditional use of DRGs or APCs only as a transactional payment model to a more dynamic payment tool that aims to link the payment for services with other metrics. Leveraging existing claims and cost data is the key in being able to quickly convert existing traditional case-mix based payment systems and/or contracting models into new ones aimed at bringing more value to the patient and reduced cost to the payer.

Results
This section will focus on the specific measures and calculations used in the programs that will be highlighted so others can see what Medicare is doing and how it's doing it. Additionally, information on how hospitals are faring under all of the different initiatives will also be shared. The focus on spending money on only high quality healthcare services is becoming more and more evident as the focus on quality measure use and development moves away from process measures to outcomes, patient experience, and efficiency...
measures. The trend here and measures used will be shared.

Conclusions
It is difficult to know whether the U.S. is achieving better value for the money spent under inpatient MS-DRG and outpatient APCs but what is clear is that new approaches are being tested and implemented which hold providers accountable more and more for the care they provide and the outcomes they are expected to achieve. They are measured against themselves and also their peers. What is clear is that under today's traditional case-mix based payment systems, more and more dollars are being placed at risk and taken away from low or poor performing hospitals and this is only going to increase over time. In addition, hospital providers are being incented more and more to provide high quality services to patients at lower cost without compromising quality and now that everything is being measured and published and CMS is using data to hold hospitals accountable, shifts are starting to occur. All of this is in hopes of improving patient quality, access, and safety while keeping overall Medicare program costs in check. Ultimately, all of the new bundled care and episode initiatives are aimed at transforming Medicare from being a passive payer to an active purchaser of healthcare services.