Value-Based Purchasing Concerns

Submitted to the Health Care Financing Task Force by the Board of Directors of the Minnesota Chapter of Physicians for a National Health Program

October 24, 2015

The legislation establishing the task force requires the task force to "consider" several methods of reducing costs and improving quality, including "expansion of value-based direct contracting with providers and other entities." The legislation also requires the task force to examine the effect of its recommendations on cost, quality, health disparities, and the health care workforce.

We would like to share with you our concern that value-based purchasing (VBP) will worsen health disparities.

Definition of "value-based purchasing"

In their presentation to Work Group 1 on October 2, Manatt, Phelps and Phillips stated, "The goal of value-based payment is to shift from paying for the amount or intensity of services to paying for the *value* created by the services."

We note first that this definition is not a definition but rather an expression of hope. We urge the task force to define clearly the mechanisms by which VBP is supposed to improve "value," as well as the parties involved – the parties who will be making and receiving the payments. In defining the parties you anticipate will receive the payments, please pick one label and use it consistently. Currently the following terms are used interchangeably:

- accountable care organizations,
- accountable care models,
- ACO arrangements,
- ACO-like contracts,
- integrated delivery systems,
- integrated health partnerships, and
- health care delivery systems.

Secondly, we call your attention to two assumptions that underlie Manatt's definition:

(1) That the current fee-for-service method of paying for medical care causes overuse and, conversely, it causes so little underuse the underuse is not worth mentioning; and

(2) VBP will reduce overuse without aggravating underuse.

We will not discuss these assumptions further. We note only that they are not supported by the evidence, that underuse is far more common than overuse, and that the focus on overuse obscures the role played by high prices and premiums, rising administrative costs, and the rapid concentration of our entire health care system induced in part by "reforms" like VBP.

Why VBP worsens health disparities

VBP worsens health disparities because value is so difficult to measure accurately, and because VBP attaches financial penalties and rewards to the measurements. If the results of inaccurate measurement of value were simply shared privately with clinics and hospitals, poorer and sicker patients would not be harmed. *It is the linking of financial penalties and rewards to inaccurate measurements of cost and quality that worsens health disparities.*

"Paying for value" requires an ability to measure both cost and quality accurately. It is possible to measure the relative cost and quality of individual medical *goods and services* with acceptable accuracy (for example, the relative values of two cancer drugs, or two methods of treating angina), but it is not yet possible to measure accurately either the cost or quality of *entire packages* of medical services provided by individual doctors, clinics, hospitals, or entities that consist of multiple clinics and hospitals. But measuring the cost and quality of entire packages of medical services – for example, the value of all services provided to all patients "attributed" to the hospitals and clinics affiliated with Park Nicollet or Winona Health in 2013 – is precisely what VBP proponents are proposing.

The two most fundamental reasons why it is difficult to measure accurately the cost or quality of entire packages of medical goods and services are:

(1) Determining when a patient "belongs" to a given doctor, clinic, hospital, or hospital-clinic chain is difficult; and

(2) Measuring accurately factors outside the control of clinics and hospitals, namely the health status and income of the patients assigned to them, is difficult and very expensive to do.

We will refer to the problem of assigning patients to a clinic or some other entity as the *attribution* problem. We will refer to the problem of adjusting cost and quality measures to reflect factors outside of provider control as the *risk-adjustment* problem. We will focus on the risk-adjustment problem because that is the defect in VPB that poses the

greatest threat to poorer and sicker people. Inaccurate attribution may contribute to health disparities as well, but the evidence for that effect is less persuasive.

We urge the task force to consult the scientific literature on this risk-adjustment issue before you endorse VBP or any recommendation that shares the assumptions that have to be true for VBP to work, such as "total cost of care" contracting, "paying for performance," and accountable care organizations (ACOs). Please do not accept the claim that this issue is trivial, or can easily be fixed at some unspecified date in the future. Please do not sign a final report from the task force recommending any form of VBP if the report fails to cite rigorously conducted research.

To whet your appetite for the research demonstrating that VBP harms poorer and sicker patients, we offer these opening paragraphs from a recent article in the *New York Times*:

> Federal policies to reward high-quality health care are unfairly penalizing doctors and hospitals that treat large numbers of poor people, according to a new report commissioned by the Obama administration….
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> Medicare and private insurers are increasingly paying health care providers according to their performance as measured by the quality of the care they provide. But, the draft report by an expert panel says, the measures of quality are fundamentally flawed because they do not recognize that it is often harder to achieve success when treating people who do not have much income or education.
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> Low-income people may be unable to afford needed medications or transportation to doctor's offices and clinics, the panel said. If they have low levels of formal education or literacy, they may have difficulty understanding or following written instructions for home care and the use of medications. In addition, the clinics and hospitals they use may lack the resources and high tech equipment needed to diagnose and treat illnesses.
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> [Robert Pear, "Health law's pay policies are skewed, panel finds" April 27, 2014, http://www.nytimes.com/2014/04/28/us/politics/health-laws-pay-policy-is-skewed-panel-finds.html?_r=0]

The report referred to in the first paragraph was based on a review of the literature on the effect of VBP on health inequality. After reviewing this evidence, the committee concluded, "There is a clear and expanding body of evidence to suggest that providers serving 'low-socio-demographic' populations and communities are more likely to be identified as 'poor performers' and either be less likely to receive financial rewards, or be more likely to face financial penalties, in pay-for-performance programs. The net effect could worsen rather than ameliorate healthcare disparities ("Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," National Quality Forum)

http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

We urge task force members to read this report and relevant studies published since that report was released, including these papers published in the last two months:

- A paper on CMS's program punishing hospitals for "excess" readmission rates in *JAMA Internal Medicine*
- A paper on CMS's VBP and readmissions program for hospitals in *Annals of Internal Medicine* http://annals.org/article.aspx?articleid=2434617;
- This editorial comment on the previously cited paper in the same edition of *Annals of Internal Medicine* http://org.salsalabs.com/o/307/images/Pay-for-Performance%20Initiatives.pdf; and
- "Assessing Medicare's hospital pay-for-performance programs and whether they are achieving their goals" in the August edition of *Health Affairs* http://content.healthaffairs.org/content/34/8/1281.abstract

The research we have cited recommends that VBP programs add income to the factors outside provider or insurer control to the risk-adjustment calculations. We agree with that recommendation. However, even if income is added to the risk-adjustment formula, current risk-adjustment models will still be very inaccurate, especially when they are applied prospectively (at the beginning of the year in which "value" will be measured). The most studied risk-adjuster in America is the one CMS uses to adjust payments it makes to Medicare Advantage plans. It can explain no more than 12 percent of the variation in expenditures among individuals. It is extremely unlikely CMS's risk adjuster will ever become more accurate because of the enormous expense of collecting and crunching more numbers on patient health and income.

The failure of all VBP programs to risk-adjust accurately means neither the quality nor the "total cost of care" scores can be accurate. Therefore, the ultimate "value" score cannot be accurate. This problem is aggravated by the need to make an arbitrary allocation of weight between the cost and quality scores, say, 40 percent to quality and 60 percent to cost.

We have previously urged the task force to investigate why DHS ejected UCare from the Medical Assistance and MinnesotaCare programs. We believe it is likely that DHS's inability to measure cost and quality accurately, and to conflate the two measures rationally into a single "value" measure, played a major role in that decision. We urge you to use DHS's decision as an opportunity to investigate the role that inaccurate risk-adjustment can play in aggravating health inequality.

Thank you.