Does Value-Based Reimbursement Threaten Our Values?

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Quick Pulse Check

- In one or two sentences:
  - Describe a moral concern you have about the move toward value-based reimbursement

Overview

Define "value"

Quick history of value-based payment

- And moral concerns raised by it
- "Everything old is new again"

A look at current controversies

What is “value”?

- The health benefit achieved per dollar spent
  - Michael Porter, NEJM
- How does that differ from cost-effectiveness?
- Let’s review what CEA is

An at risk population

Screening $	LY	$/LY	
1 m	100		

An at risk population

Screening $	LY	$/LY	
1 m	100	10k	

An at risk population

Screening $	LY	$/LY	
1 m	100	10k	
3 m	104		

An at risk population

Screening $	LY	$/LY	
1 m	100	10k	
3 m	104	29k	

An at risk population

Screening $	LY	$/LY	Δ$/ΔLY
1 m	100	10k	10k
3 m	104	29k	

An at risk population

Screening $	LY	$/LY	Δ$/ΔLY
1 m	100	10k	10k
3 m	104	29k	500k

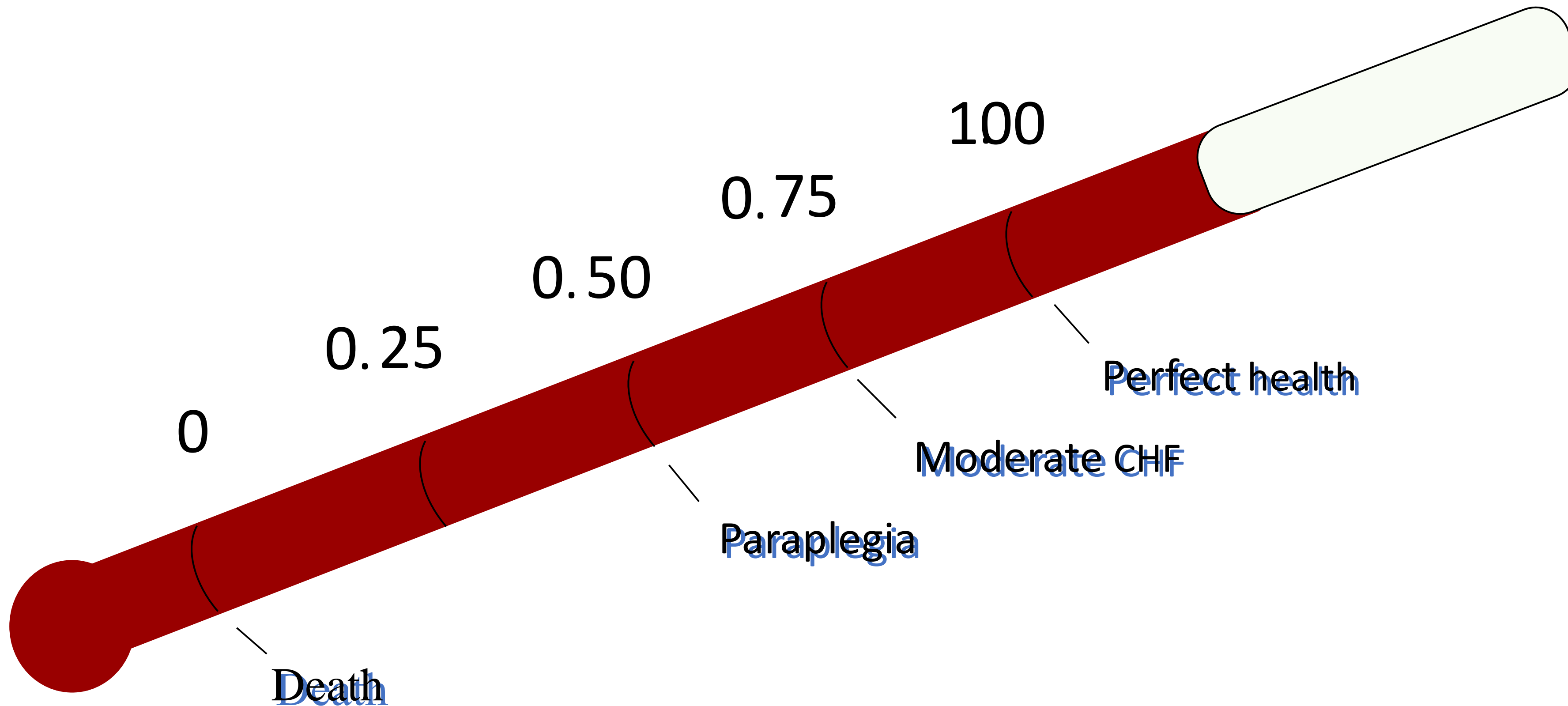
Cost-effectiveness analysis teaches us

- Not to look at
  - Cost and benefits
- But to look at
  - Incremental costs and incremental benefits
- Thus, lots of things that look pretty cheap. . .
  - Aren’t
- Ethical reflection #1: CEA vs CBA

Several Cost-effectiveness Ratios

Health Care Intervention	Incremental Cost-Effectiveness
Pap Smear every 3 years	$30,000/life saved
Arthroscopic knee surgery	$16,000/cured knee
Plantar wart treatment	$500/cured wart
Cholesterol medication	$50,000/heart attack prevented

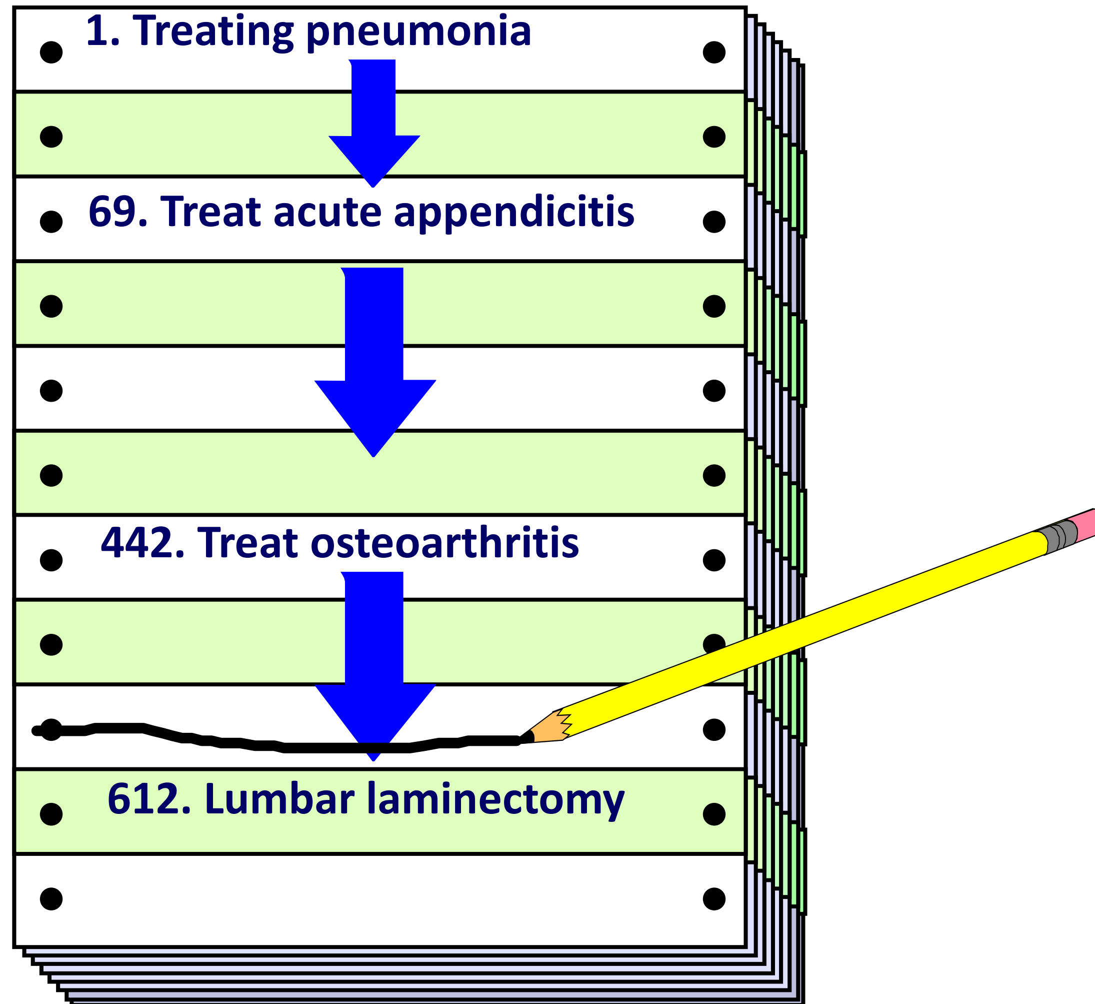
Quality Adjusted Life Years Place Health Conditions on an Interval Scale



Ways to Use CEA

- 1. Budget
- 2. Threshold
- 3. Information
- 4. Value Based Benefits Design

The Budget Approach: Drawing a Line

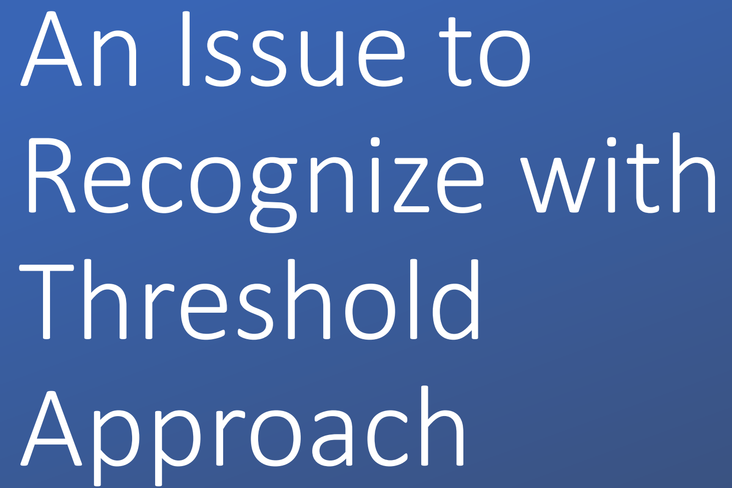


Moral controversies about CEA budgets

- When Oregon tried to base Medicaid reimbursement on CEA in the early 90s
- Criticized for De-valuing life-saving treatments
  - Treatment of acute appendicitis ranked lower than
  - Capping of exposed nerves on teeth
- Accused of discriminating againg people with disabilities
  - Whose lives weren't worth a QALY a year

2. Threshold Approach

- Pay for everything ≤ threshold
- For example
  - $50k/QALY
  - $100k/QALY
- This is used by some governments
  - Australia
  - UK: NICE



An Issue to Recognize with Threshold Approach

- If we put in hard threshold
  - Of, say, $50,000 per QALY

  - We cannot control budget
- In theory
  - If a gazillion new products came to market next year
    - With CEA of $49,000 / QALY
      - We could go bankrupt

Consider CEA and Fixed Budget

- How common is Hep C in US?
  - 1% of adults
  - But 17% of people in prison

- In 2015, less than 1% of prisoners got Hep C treatment
  - But even that cost more than $40 million

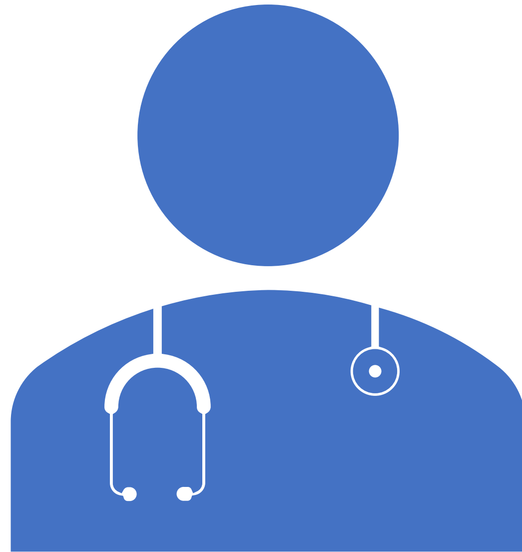
- One way to use CEA
  - Just as info to guide/inform decision making
- Who should use CEA info?
  - Insurance companies
  - Doctors
  - Others?
- How should they use it?

4. Value-Based Pricing

- The price of, say, a medication
  - Determined by its cost-effectiveness
- New chemotherapy extends life 3 months
  - Can’t price it at $100,000 per patient and count as “good value”
- What about another approach?
  - Only charge for medications when they “work”
    - CHF drug for free any year a patient admitted to hospital

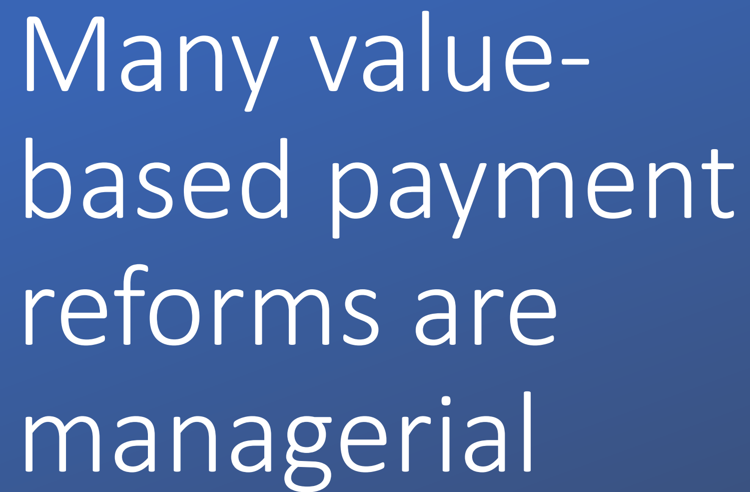
5. Value-based Payment Reforms

- Big effort to move away from FFS
  - Towards value-based payment
- Does that mean we use CEA to determine healthcare reimbursement?
- Let’s look more closely at typical VBP reforms



Example of Managerial Value

- A healthcare organization—e.g. Duke
  - Looks at inefficiencies in care of patients with heart attacks
    - e.g. Re-use of sterilized equipment; use of generic meds,…
- As a result
  - Cost of care reduced
  - With NO change in patient outcomes
- By definition: Duke has improved the value of its care
- But what do we know about whether Duke's care is
  - High value or low value?



Many value-based payment reforms are managerial

- Payers incentivize providers to
  - Reduce costs while
  - Meeting quality goals
- Medicare doing this for
  - ACOs—accountable care organizations
  - Physicians—MACRA, MIPS…

      These are acronyms for Medicare payment reforms
- If quality measures robust (a big if)
  - Then reforms can improve value
  - Without setting cost-effectiveness thresholds
    - In fact, without the gov't making ANY treatment decisions

- Cost-effectiveness, or CEA, has lots of political baggage
  - “Cost” suggests too much concern with money
  - History of its use raises concerns about rationing
- Value is better branding
  - Who could be against “promoting value”?

So What Could Go Wrong with VB Payment?

- Under VBP
  - Constrain costs
  - While maintaining or improving quality
- Let’s start with cost containment
  - Does that raise any moral concerns?
- What is more concerning
  - Moral threat of FFS or of ACO?

The Payment Continuum

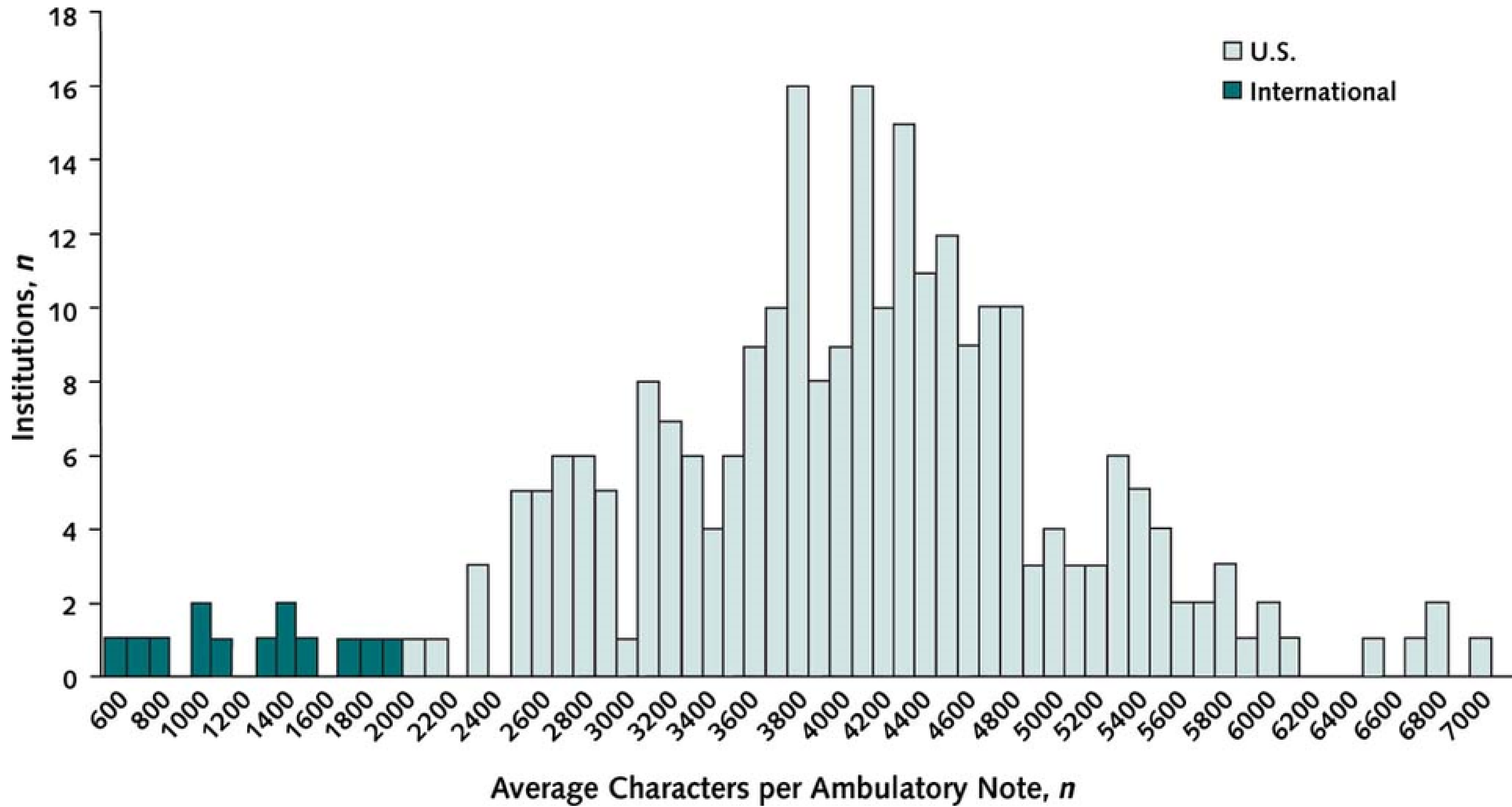
FFS | Episodes e.g. DRGs | Bundles | ACOs | Capitation

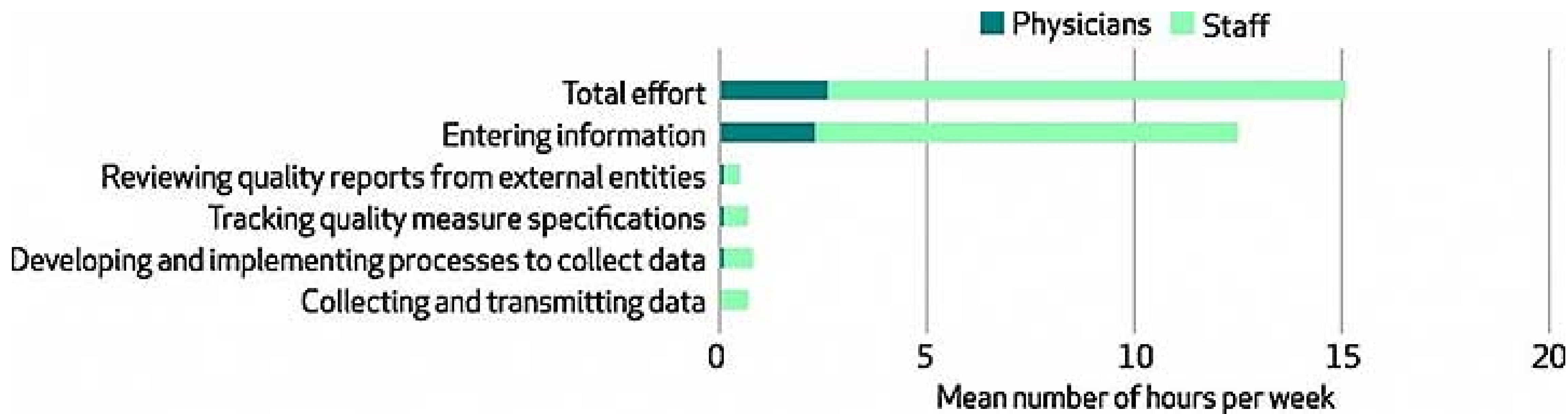
- Old
  - FFS rewards high volume
  - Capitation rewards low volume
    - Neither addressed quality
- Another old approach
  - Pay for performance rewarded quality
    - Without addressing volume
- Value based payment
  - Rewards low(ish) volume
  - And high(ish) quality

Let’s look at Quality

- Anything morally troubling about efforts to reimburse quality?

Here's a Concern I Have




Physicians
Staff
Total effort
Entering information
Reviewing quality reports from external entities
Tracking quality measure specifications
Developing and implementing processes to collect data
Collecting and transmitting data
0
5
10
15
20
Mean number of hours per week

Anything I Forgot to Talk About?

Final Thoughts

- All reimbursement systems
  - Create financial conflicts of interest
  - Focus clinician attention on what they are expected to do
    - At risk of pulling attention away from what they would otherwise do
- Must always look for balance
  - Between accountability and bureaucracy
  - Between physician duty to patient and society