Healthcare Funding News

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FROM THE EDITOR

Welcome to the Healthcare Funding team's first newsletter of 2017!

2016 was a very busy year for the team. We published several manuscripts on health care funding policy, participated in a number of events designed to highlight the use of financial incentives in the health care system, and conducted work on a variety of provincial and national health policy initiatives. This newsletter features a number of the highlights, and points to resources for further reading.

In this issue we highlight three developments:

1. We summarize a number of our newly-published manuscripts on the team's research in health funding policy.
2. We discuss a newly-published report commissioned by the C.D. Howe Institute, written by the team, on integrated funding models. In this report, we discuss the provinces' fragmented delivery systems relative to international trends towards integrated models of care.
3. We offer two commentaries on emerging topics in health policy. We discuss new federal action on federal funding for mental health and home care, and then describe some of the likely implications of the new administration south of the border vis-à-vis efforts to reform health care delivery.

We want to hear from you! We average 50 to 70 visitors per day to healthcarefunding.ca, and we respond to all reasonable email queries to editor@healthcarefunding.ca. We are soliciting suggestions on future newsletter content, new research to summarize, and general questions pertaining to our areas of expertise.

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ORIGINAL RESEARCH

Paying for Volume: British Columbia's Experiment with Funding Hospitals Based on Activity

The research team published a paper in late 2016 in *Health Policy.* This paper's focus was evaluating British Columbia's brief experiment with partially funding hospitals based on the volume and type of patients. The policy objectives underlying the reforms were to improve the efficiency and volume of hospital-based care; there were no links between the program and community-based care. The paper examined three domains of measurement: volume of hospital care, efficiency of hospital care and quality of hospital care.

The analyses found that surgical volume increased, though the lengths of stays of medical patients increased. There were no changes in alternative level of care (ALC) days, a measure of excess hospital utilization. Through the study period affected by the financial incentives, there were no measurable changes in in-hospital mortality or hospital readmission rates.

Irrespective of the impact of the reforms to hospital funding in British Columbia, the initiative has been shelved—hospitals in British Columbia have returned to being funded primarily using global budgets.

The original article can be accessed at: http://www.sciencedirect.com/science/article/pii/S0168851016302408

"…the initiative has been shelved—hospitals in British Columbia have returned to being funded primarily using global budgets."

ORIGINAL RESEARCH

New Pricing Approaches for Bundled Payments: Leveraging Clinical Standards and Regional Variations to Target Avoidable Utilization

This paper was published by the research team in late 2016. This paper's focus was evaluating the spending on stroke care across the continuum in Ontario. The paper's objectives were to measure variations in spending on stroke between regions of Ontario, and link clinical standards to trajectories of care to measure spending on ineffective care.

While hundreds of millions of dollars are spent annually on treating the outcomes of ischemic and hemorrhagic stroke, the study concluded with two findings: where one lives in Ontario is a significant factor on how much is spent on stroke care, and significant amounts of funding are directed to stroke care that experts describe as unnecessary and ineffective.

The study found that of the spending on stroke patients, during 90 day episodes of care, potentially avoidable utilization accounted for 33.5% and 28.8% of total public spending on ischemic and hemorrhagic stroke. Deeper analyses revealed that most of the gains were attributable to stroke patients exceeding their length of stay targets defined by an expert panel on stroke care.

The original article can be accessed at: http://www.sciencedirect.com/science/article/pii/S0168851016300227

"...significant amounts of funding are directed to stroke care that experts describe as unnecessary and ineffective."

POLICY DISCUSSION

Integrated Funding: Connecting the Silos for the Healthcare We Need

CD Howe Institute, Commentary No. 463

In this policy review, we examine the impacts of the fragmented state of provinces' health care systems, review international initiatives designed to break down the silos to improve health care across the care continuum, and based on a synthesis of findings, provide a number of recommendations to health care decision-makers to consider regarding integrated payment methods. The report can be found at: https://www.cdhowe.org/public-policy-research/integrated-funding-connecting-silos-healthcare-we-need

The report's key lessons for decision makers include:

- The impact of new payment models depends on the legacy systems they replace.
- Consider legislative and regulatory barriers to reforms.
- Prepare for mergers and organizational restructuring.
- Recognize that physician engagement and leadership is crucial.
- Pay for what you can measure.
- Manage financial risk.

Based on the key lessons, and synthesizing other countries experiences, recommendations include:

- Articulate a clear national vision and end goal for integrated payment models.
- Establish a national centre of excellence in payment and delivery models, with provincial spokes.
- Engage physician groups at the national and provincial levels.
- Build analytic capacity at the national, provincial, and regional levels.
- Design and implement demonstration projects with an eye toward evaluation and either scaling up or winding down.

"...if the provinces are to reap the advantages... from integrated payment models, they will need serious reforms of both global budgets... and fee-for-service payment models..." p.13

The report concludes that innovations and new methods for paying for health services in other countries are breaking down the silos between settings that are endemic within provincial health systems. Sustainability continues to dominate health care discussions; however, whether decision-makers are willing to tackle the longstanding siloes to improve effectiveness of the health systems is unclear.

COMMENTARY

New Federal Funding for Mental Health and Home Care: What Are We Buying?

Over the past month, Canadians have witnessed their provincial and territorial health and finance ministers haggling with their federal counterparts—Health Minister Jane Philpott and Finance Minister Bill Morneau—for additional health care dollars. The feds have taken the position that any money on top of the 3.5% global health care funding increase they have put on the table needs to be tied to targeted investments in mental health and home care.

The intent behind earmarking this funding is commendable: mental health and home care services have long been the poor cousins of hospital and physician services in Canada, shut out of the *Canada Health Act's* definition of "medically necessary services" that require first dollar public coverage from provinces and territories. Both have also come under heavy strain in the past decade as a result of changing demographics and patterns of health system utilization.

With the move toward de-institutionalization of mental health care, services that were once provided within publicly funded inpatient hospital settings are now predominately provided by community mental health organizations and a limited supply of community-based psychiatrists. In home care, the three-pronged storm of aging demographics, pressures on hospitals to reduce hospital length of stay, and provincial efforts to avoid long-term care institutionalization have exponentially increased demand for home-based services.

Funding for health care services flows through payment models to health care providers. In this respect, mental health and home care are again poor cousins to hospital and physician services: across Canada, there are a hodgepodge of different payment methods used to fund these services, primarily using some variety of historically-driven global budgets.

"...mental health and home care services... have come under heavy strain in the past decade as a result of changing demographics and patterns of health system utilization."

The problem with throwing more money at health care through historically-driven funding models is that payers (provincial governments) don't know what they're buying. And if they want to buy change in mental health or home care, using the same payment models they will inevitably end up buying more of the same. The lessons of the 2004 Canada Health Accord are instructive in this respect: over 10 years, $41 billion was dished out in attempts to buy "a fix for a generation," only to end up transferring wealth to existing health care providers by paying them more to do simply more of the same thing.

One of the few success stories from the 2004 agreement was the reduction in wait times for elective

surgeries in a number of provinces. The most successful provinces in this objective—including Ontario, Alberta and British Columbia—used varieties of case-based payment models to tie the additional funding to performing additional volumes of surgeries. While it might be argued that provinces overpaid hospitals for these additional volumes—previous research conducted by Sutherland into the marginal costs of hospital services in British Columbia suggests this was almost certainly the case (http://www.healthpolicyjrnl.com/article/S0168-8510(15)00118-9/abstract)—at least the government in BC was able to show a clear linkage between funding disbursed and the results achieved.

No such mechanisms currently exist in the Canadian funding landscape for mental health and home care services, outside of a limited stream of case-based funding provided in Ontario for home care for joint replacement cases. Ontario has also made the furthest inroads into mental health funding with the development of a case mix system for inpatient mental health services, the System for Classification of In-Patient Psychiatry (SCIPP). However, the system is currently "turned off" in Ontario's provincial funding allocation model (http://www.oha.com/CurrentIssues/Issues/HSFR/Documents/HBAM%20Results%20for%20Posting%20v1-3%20(2016-11-16).pdf) and its inpatient scope does little for funding mental health services in the community, where much of the federal money is likely to be directed.

In the coming months, our team will be exploring options for introducing new payment models in the mental health and home care sectors in Canada. While a less well-developed policy space on the international policy stage than payment systems for acute care services, recent years have seen a number of innovative payment models for mental health and home care services introduced in the United States and Europe.

For example, this past year England has launched a national payment policy for commissioning mental health services using a combination of episodic and capitation-based mental health tariffs (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499488/Guidance_on_mental_health_currencies_and_payment_final.pdf). Of particular interest in this payment system is the setting-independent nature of the episodic payments assigned to mental health "clusters" (patient groups), where a single payment for an episode of psychosis spanning several months may cross a combination of inpatient and outpatient services. Similar integrated payment models for mental health care would be conceptually appealing for Canadian payers as well.

Also this past year in the United States, the Centers for Medicare and Medicaid Services (CMS) have introduced a new Home Health Value-Based Purchasing Model that will tie an increasing proportion of reimbursement to home health service providers to a set of outcome and process measures such as improvements in activities of daily living, hospitalizations and vaccinations (https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model).

Home care providers have also figured prominently in CMS' post-acute bundled payment initiatives, where the same payment is provided for an episode of post-acute care regardless of whether it is provided by an inpatient rehabilitation facility, skilled nursing facility or home health care provider. By their design, these models steer health systems towards increasing use of home care as a more cost-effective substitute for expensive institutional post-acute care settings (http://homehealthcarenews.com/2016/09/cms-bundled-payments-are-driving-more-care-to-home-health/). Similar models may also be effective in promoting more efficient use of post-acute care in Canada, where studies have shown wide variation in the use of institutional settings versus home care (https://www.ncbi.nlm.nih.gov/pubmed/22386890).

As the federal and provincial governments consider injecting massive amounts of new money into home care and mental health services, they would do well to think about what they are paying for with this new money. We will explore these options further in the coming months through a new policy brief.

COMMENTARY

Health Care Payment Reform in the Age of Trump: A Look Southward and Forward from the Canadian Health Policy Perspective

For all the Canadian health policy wonks looking south of the border to an impending four years under President Donald J. Trump, there has been relatively little insight available from the Canadian media on the incoming administration's plans for reshaping health care in the United States.

Most Canadians' knowledge of Trump's health care agenda starts and stops with his ubiquitous "repeal and replace" mantra, adopted by the Republicans as their rallying cry against the *Patient Protection and Affordable Care Act* (ACA), popularly known as "Obamacare". There is broad awareness that the "repeal" effort will have a significant, likely negative effect on many Americans' health insurance coverage. But there is little understanding of what form the "replace" may take, or what the Trump regime's vision for reforming the United States health care system looks like beyond the debate over health insurance—and what the implications of these efforts may be for Canada.

There are some obvious reasons for this lack of Canadian media interest. First off, health care is typically considered to be a largely domestic issue; media attention outside of the US has focused mainly on Trump's implications for policy files that have a greater perceived global impact such as trade, immigration, the environment, foreign policy and defense.

Second, there is very little concrete policy to discuss, as Trump's health care platform is a thin one. Beyond "repeal and replace", Trump has offered up few details on the broader policies and reforms that he intends to push over the next four years, including what the Obamacare "replacement" will look like—other than helpfully noting that it will be "something terrific" (Ferris, 2015).

"…there has been relatively little insight available from the Canadian media on the incoming administration's plans for reshaping health care in the United States."

Finally, with the focus of the public debate over the ACA mainly resting on health insurance, many Canadians—comfortably ensconced in our single payer system, with publicly funded universal health care revered as a pillar of our national pride (Sinha, 2013)—view our neighbours' trials and tribulations over something that we consider so essential with a mixture of curiosity and pity. With the spectre of more than 20 million Americans facing elimination of their insurance coverage gained through the ACA's fragile architecture of subsidies, tax penalties and federal funding for state Medicaid expansions, the debate over the future of the ACA may strike many Canadians as a relic from a more brutish era.

But Trump's impact on health care—like the scope of the ACA itself—goes far beyond health insurance. There are many good reasons why any Canadian with an interest in health policy—especially those interested in the design of health care payment and delivery systems—should care about the health reform plans of Trump and his pick for Secretary of Health and Human Services, Tom Price.

Here, we explore a few of those reasons, with a focus on some of the likely effects on US payment and delivery reforms and their indirect impacts on Canadian health care.

Beyond insurance: the *Affordable Care Act's* suite of payment and delivery system reforms

By one estimate, only a few dozen of the 424 total sections in the 2000-plus pages of the Affordable Care Act are concerned with health insurance (Wynne, 2016). The rest of the act legislates a broad collection

of reforms to the United States health care payment, delivery and research systems: from Accountable Care Organizations and bundled payments to patient-centred primary care medical homes to a billion dollar agenda for comparative effectiveness research, many of these policies have largely flown under the public radar. Despite their lack of attention outside policy circles, these reforms have had major impacts on American health care in the years since the ACA was passed. First only recognized in the health services and policy literature, their impacts and are now starting to get attention in the US mainstream media (Goodnough & Pear, 2016).

In contrast to the ACA's complex and delicate web of initiatives to expand health insurance coverage, which has little relevance for Canadian health care decision makers, the ACA's payment and delivery reform initiatives have had a significant influence on Canadian policy makers, policy researchers and thought leaders. While they are being implemented in a very different national health care system, many of these initiatives have appeal as potential solutions for addressing similar problems in Canadian provincial health systems.

Under the auspices of the ACA, the Centers for Medicare and Medicaid Services (CMS) has initiated perhaps the most ambitious set of payment and delivery system reforms in health care history. Attracting a great deal of national health sector attention, Medicare's Value-Based Purchasing and Readmissions Reduction incentive programs levy penalties for outcomes and quality processes for every major Medicare-funded hospital in the country. In primary care, the Patient-Centred Medical Home program provides payment incentives to providers that adopt key structural elements for providing coordinated care, such as an interdisciplinary team, after-hours access and electronic health records.

Some of the most-watched models rolled out through the ACA are Accountable Care Organizations (ACOs) and bundled payments, both of which set total cost benchmarks across groups of previously disparate fee-for-service provider entities such as hospitals, physicians and nursing facilities, in order to build shared incentives for reducing costs and improving quality of care—either for defined hospital-initiated episodes of care, in the case of bundled payments, or ongoing care for populations of Medicare beneficiaries treated, in the case of Account ACOs. In 2016, an estimated 11.2 million Americans were covered under Medicare and Medicaid ACOs (Muhlestein & McLellan, 2016). Medicare's Bundled Payments for Care Improvement initiative has 1364 participating entities, while Medicare's mandatory Comprehensive Care for Joint Replacement bundled payment program has 800 mandatory hospital participants (CMS, 2016; Definitive Healthcare, 2016).

"...the ACA's payment and delivery reform initiatives have had a significant influence on Canadian policy makers, policy researchers and thought leaders."

Although not included in the ACA itself, the Act also laid the foundation for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which instituted far-reaching reforms to the way United States physicians are compensated. Passed with rare bipartisan support, MACRA decrees that starting in 2019, all Medicare-compensated physicians in the country will have a portion of their reimbursement tied to a set of specialty-specific quality indicators under the bill's Merit-based Incentive Payment System, with the only exception being physicians that have already signed on to alternate payment models such as bundled payments or ACOs (AAFP, 2016). MACRA marks the introduction of perhaps the most significant physician pay-for-performance program in global health care history.

Beyond the new payment models themselves, the ACA also established a $1.5 billion institution—the Centre for Medicare and Medicaid Innovation (CMMI)—specifically designed to rigorously evaluate this broad and diverse portfolio of payment and delivery system reforms. Crucially, the CMMI has the legislated authority to pursue national scale-out of models that successfully pass the Centre's "signature test" for reducing health care spending while maintaining quality or improving quality while maintaining current spending levels. CMMI is currently operating 79 different demonstration projects, out of which two so far—the Pioneer Accountable Care Organization model and the Medicare Diabetes Prevention Program—have successfully passed the signature test (Centers for Medicare and Medicaid Services, 2016b).

In the past year, CMMI has pushed its payment reform agenda even further by implementing mandatory national demonstration projects, beginning with the Comprehensive Care for Joint Replacement bundled payment model for hip and knee replacement. Similar mandatory bundled payment programs for hip fracture and cardiac care are planned for the coming year (Centers for Medicare and Medicaid Services, 2016a). Under these programs, a randomized selection of Medicare service areas are required to adopt these new payment models, allowing for a rigorous randomized evaluation to be conducted. These non-voluntary payment innovations, enabled by the powerful authority granted to CMMI under the ACA, have served to both reinforce the national vision of the Obama administration's payment reform agenda and to upset a number of health care stakeholders, including Trump's new Secretary of Health and Human Services.

Follow the leader: Obamacare's spillover effect on Canadian health policy

The ambition and scope of the US payment reform agenda—CMS has set a goal of tying 50% of all previously fee-for-service Medicare payments to quality or value through alternative payment models by 2018 (Centers for Medicare and Medicaid Services, 2016c)—has thrown down a gauntlet to the leaders of Canada's own troubled health care systems, who have been challenged to think about how to advance a similarly ambitious transformation agenda in our own troubled provincial health care payment and delivery systems (Boozary & Forest, 2014). With the ACA's huge and rapid reform agenda, our typically stodgy Canadian health systems are able to play "follow the leader" with the innovations we see being introduced south of our border.

CMS' innovative payment models have inspired a wave of Canadian research, policy development and opinion pieces. Canadian researchers have used Ontario data to simulate the design and impacts of bundled payment models, using an episode of care approach to reveal new insights around regional variations in spending and quality (Hellsten, Chu, Crump, Yu, & Sutherland, 2016; Sutherland, Hellsten, & Yu, 2012). Similar research efforts have modelled options for establishing ACO-like structures in Canada, again using Ontario data (Huynh et al., 2014). Medicare's Hospital Readmissions Reduction program has stimulated policy discussions around implementing similar policies in Ontario (Baker, 2011), while researchers have simulated the effect of such a program on hospitals in British Columbia (Hellsten, Liu, Yue, Gao, & Sutherland, 2016).

Canadian policy researchers and thought leaders have also proposed the need for a similar made-in-Canada version of CMMI to evaluate Canadian payment and delivery system reforms, recognizing that too often innovative Canadian initiatives are rolled out on a province-wide basis without being properly studied (Advisory Panel on Healthcare Innovation, 2015; Glauser, Nolan, & Petch, 2016).

In 2015, members of Health Canada's national panel on health care innovation made a site visit to CMMI to learn about the payment innovations under the ACA and the operations of CMMI in order to inform their own policy recommendations for Canada. The Advisory Panel recommended the introduction and evaluation of bundled payment- and ACO-style models across the

provinces, recognizing their potential effectiveness for transforming Canadian health care (Advisory Panel on Healthcare Innovation, 2015).

Beyond the research and policy discussion inspired by the ACA, similar demonstration projections have been introduced in Canada: the Ontario government introduced a pilot "bundled care" project for several chronic disease and surgery populations in St Joseph's Health Care System in Hamilton beginning in 2011 (Ontario Ministry of Health and Long-Term Care, 2015b), and followed this by recently introduced a series of integrated funding pilots that draw heavily from the concepts advanced by the US bundled payment program (Ontario Ministry of Health and Long-Term Care, 2015a).

The great repeal: Wither Obamacare?

Canadians involved in health policy are now asking: what is the prognosis for all these reforms in the United States over the next four years, given that Trump has been all but silent on these policy areas throughout his campaign?

In the absence of any detailed Trump policy proposals beyond "repeal and replace" and a lack of general consensus among Republican Party lawmakers on the details of the ACA's replacement, the best clues to the new administration's future health care plans may lie in the people that Trump has selected to run the portfolio: Tom Price, Trump's pick for Secretary of Health and Human Services.

A former orthopaedic surgeon, Tom Price has spent the past 12 years in Congress as a representative for Georgia's 6th district. Price has long been a staunch advocate for reduced government involvement in health care and a cheerleader for free market principles, while attracting attention for his opposition to abortion rights. He has been a champion for the clinical and financial autonomy of physicians, opposing government involvement in setting and monitoring standards of care, while challenging physician antitrust legislation (Glied & Frank, 2016). Not surprisingly, Price has been a similarly fervent opponent of the ACA: he eulogized its passing in 2010 by stating that it was "a dark day for America," and that "our founders are weeping" over a bill that was "an affront to federalism, an affront to individual liberty." (Pear, 2016).

In combination with his agenda for reduced government involvement in health care, Price has also long advocated for sweeping cuts to Medicare and Medicaid. In a 2015 bill that he introduced to Congress as a proposed replacement for the ACA, Price proposed shifting individuals to a defined contribution-based voucher system for health care insurance, with voucher subsidies based on age, rather than on income—essentially removing any additional support provided to low income individuals. Price's proposed health insurance reforms are explored in more detail elsewhere (Glied & Frank, 2016); in this article, we focus on the implications of his positions and statements on provider payment and delivery systems.

Price has publicly taken issue with the aggressive payment reform direction now being pursued by CMS and CMMI. In 2015, Price and other Republican congressmen took issue with CMS' introduction of the Comprehensive Care for Joint Replacement mandatory bundled payment demonstration, writing a letter to CMS (Price, 2015) and introducing a piece of legislation in 2016—the Healthy Inpatient Procedures Act (Price, 2016)—seeking to delay the introduction of the new model.

Shortly before the November 8 election, Price also wrote a letter with other Republican lawmakers to the CMS administration slamming the CMMI's recent introduction of several mandatory bundled payment models and drug payment reforms. Similar to their opposition to the Comprehensive Care for Joint Replacement demonstration, Price and colleagues objected to the mandatory nature of these reforms, arguing that "until recently, the tests and models developed by CMMI were implemented as intended, on a voluntary, limited-scale basis where no state, healthcare provider, or health insurer had any obligation to participate". According to Price, CMMI had now "exceeded its authority"; the letter requested that CMS "cease all

current and future planned mandatory initiatives under the CMMI" (Price, Boustany, & Paulsen, 2016).

Price's enmity toward CMMI is shared by many of his Republican colleagues: House Speaker Paul Ryan's 2016 Republican congressional Health Care Reform Task Force plan states that CMMI is "operating beyond its intended authority, with a complete lack of transparency and disregard for the input of stakeholders most affected by their proposals", and further that "CMMI's experiments on seniors' health services could limit access to care for Medicare's sickest beneficiaries and disrupt how health care providers serve patients in the future". Ryan's plan proposes to repeal CMMI when its current funding expires on January 1, 2020 (Health Care Reform Task Force, 2016).

In another example of attempting to put the brakes on payment reform, Price expressed concern with the requirements for physicians under the MACRA suite of physician payment initiatives. Although Price voted along with other Republican lawmakers in favour of MACRA in 2015, with the release of the final MACRA rule he released a statement indicating that he was "deeply concerned about how this rule could affect the patient-doctor relationship", pointing to the administrative burden for physicians created by increased quality reporting requirements under the Act and potential disruptive effects on small physician practices. (Price & Roe, 2016).

An imminent shift in direction: Devolving Medicare and Medicaid to states and insurance plans

While Tom Price and his Republican colleagues are less than enamoured with many of the recent federal health care reforms pushed through Medicare and Medicaid under the ACA, arguing against what they perceive as federal government overreach in these areas, there is one Medicare program that they have expressed broadly positive views on: Medicare Advantage.

Less familiar to many Canadian health policy experts than traditional Medicare fee-for-service, Medicare Advantage allows Medicare beneficiaries to receive coverage from their choice of private health plans operating in their region. Medicare pays plans a risk-adjusted capitated payment for each Medicare beneficiary enrolled in their plan, with the payment set according to a benchmark based on regional per capita spending benchmarks under Medicare fee-for-service. Medicare Advantage plans—many of which operate as health maintenance organizations (HMOs)—often offer additional services over those provided in Medicare fee-for-service, such as case management and health promotion programs. CMS publishes annual quality ratings of Medicare Advantage plans using an aggregated 5-star rating system, with higher ratings being tied to bonus payments and more flexible in-year enrolment options for plans (Centers for Medicare and Medicaid Services, 2017).

Enrolment in Medicare Advantage has been growing over the past decade: in 2015, 16.7 million people—or 30 percent of total Medicare beneficiaries—were enrolled in Medicare Advantage plans (Medicare Payment Advisory Committee, 2016). The program's steadily increasing size and popularity has surprised some policy experts, especially given the implementation of significant cuts and hard caps to plans' capitation payments under the ACA, estimated at $150 billion by Republicans (Health Care Reform Task Force, 2016).

While not a favourite of the Obama administration, Republicans favour the private, market-based approach of Medicare Advantage plans (Ferguson, Harris, & Jones, 2016). As Chair of the House Budget Committee, Tom Price expressed support for expanding the program in the Committee's 2017 budget plan, and further favouring the program by requiring Medicare fee-for-service to compete with private Medicare Advantage plans (US House of Representatives Committee on the Budget, 2016). This support for expanding and increasing the flexibility of Medicare Advantage has been echoed by Paul Ryan and congressional colleagues in their A Better Way plan (Health Care Reform Task Force, 2016).

While critics may (perhaps rightly) attribute the Republicans' support for Medicare Advantage to ideological desires to dismantle and privatize Medicare, it is worth considering some of the recent objective evidence for the performance of the program. Historically, this program was viewed by health services researchers as an underperforming program that offered Medicare poor value for money: data suggested that health plans often engaged in cream-skimming of healthier beneficiaries, receiving higher payments from Medicare for their beneficiaries than would have been the case under fee-for-service. Reforms to the Medicare Advantage capitation risk adjustment methodology introduced in 2004—which began to more accurately account for differences in morbidity among beneficiaries—as well as cuts and caps to overall capitation payments have now brought average costs per beneficiary within a few percentage points of expected costs under the fee-for-service program (Newhouse & McGuire, 2014).

Most importantly, recent data on the performance of Medicare Advantage plans suggest that on average, beneficiaries enrolled in the program have modestly better outcomes and higher quality care on a number of measures than beneficiaries enrolled in traditional Medicare fee-for-service. On average, Medicare Advantage enrollees experience lower rates of preventable hospitalizations, readmissions and potentially inappropriate elective procedures than their Medicare fee-for-service counterparts. Researchers attribute this superior performance to the HMO and managed care structures of many Medicare Advantage plans, where they organize and coordinate care for their beneficiaries in a more integrated way than the care typically delivered under the traditional fee-for-service system. Many Medicare Advantage plans have implemented innovative disease management and behavioural health programs that would be difficult to implement in traditional Medicare fee-for-service (Huckfeldt, Escarce, Rabideau, Karaca-Mandic, & Sood, 2017; Newhouse & McGuire, 2014).

Similar to their approach to promoting non-government options in Medicare, Price and the Republicans would like to take a similarly devolutionary approach toward Medicaid. Price's 2016 congressional budget plan proposes creating "state flexibility funds" to fund state Medicaid programs—essentially, fixed block grants—in place of the current federal-state cost sharing arrangements, and liberating states from a range of current federal standards and regulations on how they operate their programs. Unlike their Medicare Advantage plans, there is little evidence to support the viability of such an approach, and critics charge that the strategy is essentially a way to starve Medicaid programs of funding. Republicans tout the strategy as enabling states to innovate and develop local alternatives to federal programs (US House of Representatives Committee on the Budget, 2016).

Looking ahead: What might Trump mean for Canadian health care?

Overall, we anticipate that many Canadian health care researchers and policy makers will likely be disappointed in the health care actions taken by the new Trump administration. There will almost certainly be a slowdown in the current pace of the federal Medicare payment transformation initiatives that Canadian policy makers and researchers have watched with so much interest. As Secretary for Health and Human Services, Tom Price has broad executive powers to freeze or completely halt range of Medicare and Medicaid initiatives—powers that he may exercise as soon as he takes office.

Based on his past record, it is very likely that Price will take a more cautious approach to implementing many of the national reforms that Canadians have been watching with some interest, and may opt to completely roll back others. Some of the ACA-linked initiatives that the Republicans dislike may now be too firmly entrenched to roll back—for example, the Comprehensive Care for Joint Replacement mandatory demonstration will have been in place for nearly a year, with many service providers already having made major changes and investments to adapt to the model.

Others, such as CMMI's planned next wave of mandatory bundled payment projects, will likely be on Price's chopping block.

On the plus side, Canadians looking to the United States for ideas on payment and delivery system reform can rest assured that such reforms will continue. Republicans have publicly expressed support for the goal of shifting US health care away from traditional fee-for-service towards value-based payment mechanisms (Health Care Reform Task Force, 2016). Over the coming four years, as the pace of innovation at the federal level slows, there will continue to be a rapid shift to new payment models at the level of states and health plans. As the Republicans take steps to expand the Medicare Advantage programs, high-performing health systems, such as Kaiser Permenante, will continue to transform health care at the regional level through innovative delivery models.

While slowing down the pace of the more visible federal efforts to move US health care providers to participate in integrated, risk-sharing models such as Accountable Care Organizations and bundled payments, similar movements at the state and health plan level may push the country toward roughly the same goals. Policy researchers have noted the similarities between Accountable Care Organizations and vertically integrated private HMOs, noting that as Accountable Care Organizations mature, many may in fact choose to operate as Medicare Advantage plans in the future (Chernew, McGuire, & McWilliams, 2014).

At the state level, the Republicans seem set to allow states to liberally use what are known as Section 1115 waivers to provide them with exemptions to operate state-wide demonstration projects, essentially allowing them to "opt out" of the conventional rules of federal programs like Medicare and Medicaid to develop customized approaches to organizing their payment and delivery systems. States such as Vermont and Massachusetts have already shown some innovative strategies through this approach, implementing state-wide Accountable Care Organization or "global payment" systems. Canadians with an interest in health policy would do well to follow these US regional initiatives.

For health policy observers, the greatest losses inflicted by Trump and Price's devolutionary approach will be the weakening of the Obama administration's strong push for a coordinated federal approach to implementing reforms—resulting in increased fragmentation at the sub-national level—and the very likely dismantling of CMMI. While CMMI is funded until the end of 2019, Price and his Republican colleagues will likely steer away from making full use of CMMI's broad legislated mandate powers for fear of criticism of letting unelected bureaucrats control the system, and instead may turn much of CMMI's legislated independent authority back over to Congress. These steps will seriously damage the capacity of the United States to design, coordinate and rigorously and effectively evaluate new payment models. For instance, it is highly unlikely that the Republicans will support future mandatory demonstration projects, which are the most effective way to allow for the rigorous, randomized evaluation of policy interventions.

Ultimately, even with the clues that are discussed here, Canadians can only speculate on the details of the actions that will be taken by the Trump administration. If the President-elect has demonstrated anything thus far, it is that his only predictable characteristic is unpredictability. This uncertainty over what the next four years holds is a key source of anxiety for many Americans working in the health care space; President Obama himself penned a recent editorial in the New England Journal of Medicine highlighting the recklessness of repealing the ACA without a clear replacement in sight (Obama, 2017).

With these general uncertainties aside, there are a few broad predictions that can be safely made around United States health care over the next four years. First, the shift toward value-based payment reform will continue under the new administration; there is little appetite by health leaders for a wholesale return to traditional fee-for-service. Second, the leadership for this shift will be increasingly ceded by CMS to states

and health plans. Finally, while many of these state and plan-level efforts will push in the same general direction as federal payment reforms—bridging payment silos and sharing collective risk for costs and outcomes—the landscape of payment and delivery system innovations will become much more fragmented, with far less capacity at the federal level to effectively evaluate this complex national landscape of reforms.

It seems likely that Canadians working in health policy will be spending considerably less time watching our neighbours' national policy efforts over the next four years. We would do well to spend the time taking lessons from what they have accomplished and implementing our own innovative health care payment and delivery system reforms.

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