COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES
An affiliate of the AMGA Foundation

The Journey to Pay-for-Performance: Medical Group Leaders Cite Five Drivers of Successful Risk Adoption

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How goes the journey toward pay-for-performance? According to two recent surveys, there is considerable progress, but leading medical groups say it's time to step up the march toward a value-based payment health care system.

Interviews with 10 leaders of major medical groups in markets around the U.S. – all members of the Council of Accountable Physician Practices (CAPP) – plus insights from the most recent American Medical Group Association (AMGA) survey identify the milestones, incentives, and barriers in the roadmap toward pay-for-performance.

MEDICARE ADVANTAGE IS THE GREAT TEACHER

Experience with Medicare Advantage (MA) programs provided the foundation to incorporate risk into health care delivery and continues to be an ongoing "university" for innovation. In fact, Medicare Advantage is the market leader in the uptake of risk-bearing contracts today.

In Medicare Advantage, capitated payments from health plans to medical groups provide a cash flow model that enables groups to build robust care coordination and chronic disease management programs, and to use multi-disciplinary teams supported with data and digital tools. These programs and tools are now migrating across the continuum of risk-based contracts beyond MA, serving as the foundation for more sophisticated population health and care management initiatives.

Medicare Advantage programs are broadly viewed as successful and one-third of Medicare beneficiaries — 22 million seniors — were enrolled in MA plans in 2019. According to AMGA's "Taking Risk 4.0" survey, medical groups reported an increase in MA revenue from 22 percent in 2015 to 30 percent in 2018, and they project that this growth will continue. They are increasingly taking full capitation and other two-sided risk arrangements in their MA contracts; this is particularly true for groups with 500 or more clinicians.

ACOS MOVE PAY-FOR-PERFORMANCE BEYOND MEDICARE ADVANTAGE

These medical groups are participants in Medicare's Accountable Care Organizations, bundled payments, and other models to bring coordinated care to the traditional Medicare population. Several groups are leading Medicare ACOs that organize and coordinate independent practices and hospitals. Almost all of the physician leaders interviewed noted that care management teams

and tools created for their Medicare Advantage patients were extended to their Medicare ACO patients, and even their Medicare patients enrolled in traditional fee-for-service.

Within the ACOs, initiatives that support the move from volume to value include:

- Engaging specialists as champions and collaborators
- Shifting and evolving roles to develop new functions and staff care management processes
- Improving transparency so that information on relative outcomes and performance can be shared across the care team

A majority of the leaders interviewed report that they have expanded their ACO network beyond their core medical group to partner with community practices and share their care coordination services. These models continue to transform the way that care is delivered to more Medicare patients in their local communities.

EMPLOYERS REPRESENT THE "NEXT FRONTIER" FOR RISK CONTRACTING AND POPULATION HEALTH

Contracting directly with employers is the next frontier in risk-based contracting for medical groups and they are enthusiastic about this opportunity.

Several of the medical groups interviewed have already entered risk-based contracts with large employers and are planning to build on this success. Groups are also serving as high-performing networks and centers of excellence for high volume, high-cost procedures for employers. These arrangements include financial risk-sharing and quality targets, and some include performance guarantees.

As these relationships evolve, the groups pointed out how such employer-provider collaborations can generate innovative solutions that pair integrated care with convenient, high-value primary care experiences, especially as employers consider options such as workplace clinics.

RISK MODELS AND QUALITY OF CARE GO HAND-IN HAND

As experience with risk-based models increases, research is demonstrating that integrated, coordinated care developed through population health produces better clinical outcomes.

In a report released earlier in 2019 by the Integrated Healthcare Association, shared financial risk was found to produce both better quality performance and lower costs. Another study from the National Bureau of Economic Research found that integrated medical groups were able to provide a higher level of care to patients with complex and chronic illness, at significantly less cost. Encouraging results from several years of physician group performance under the risk-based "Alternative Quality Contract" (AQC) developed by Blue Cross of Massachusetts were published in 2019. Spending was lower and quality improved compared to a cohort of patients not enrolled in the AQC.

Early results from the centers of excellence models suggest integrated medical groups can identify and avoid inappropriate procedures and deliver safe, reliable, evidence-based care in appropriate settings, with lower complication rates and faster return to function for patients.

CMS CONTINUES TO USE POLICY TO DRIVE THE TRANSFORMATION

In addition to the momentum already created, these medical group leaders called on the Centers for Medicare & Medicaid Services (CMS) to continue to use policy to drive the adoption of pay-for-performance and alternative payment models.

Specific steps that CMS can take to accelerate the transformation include:

- Using the Quality Payment Program to engage more physicians in the transition to value. Today, nearly 60 percent of clinicians are exempt from the Merit-Based Incentive Payment System (MIPS), traditional Medicare's pay-for-performance program. Increasing participation in these programs is one way to prepare clinicians for the move to risk-based models.

- Continued emphasis by CMS and the Center for Medicare and Medicaid Innovation (CMMI) to bring new payment models to traditional Medicare, particularly total cost of care models. Groups surveyed called on CMS to accelerate its work and to focus on models that include collaborations across payer types. Primary Care First allows for multi-payer participation. The Medicare direct-contracting model may enable physicians groups, health plans, and other vendors or partners to collaborate with greater flexibility than in traditional Medicare.

- Aligning models across payer types reduces administrative hurdles and allows meaningful comparisons across different models. One example is quality measurement: Models and payers use different sets of measures, which creates additional burdens for medical groups and confusion in comparing providers and programs. Quality metrics need to be aligned to get a clear picture of results and to lower the administrative burden of collecting and reporting this data.

PROGRESS TOWARD A PAY-FOR-PERFORMANCE HEALTH CARE SYSTEM MUST CONTINUE

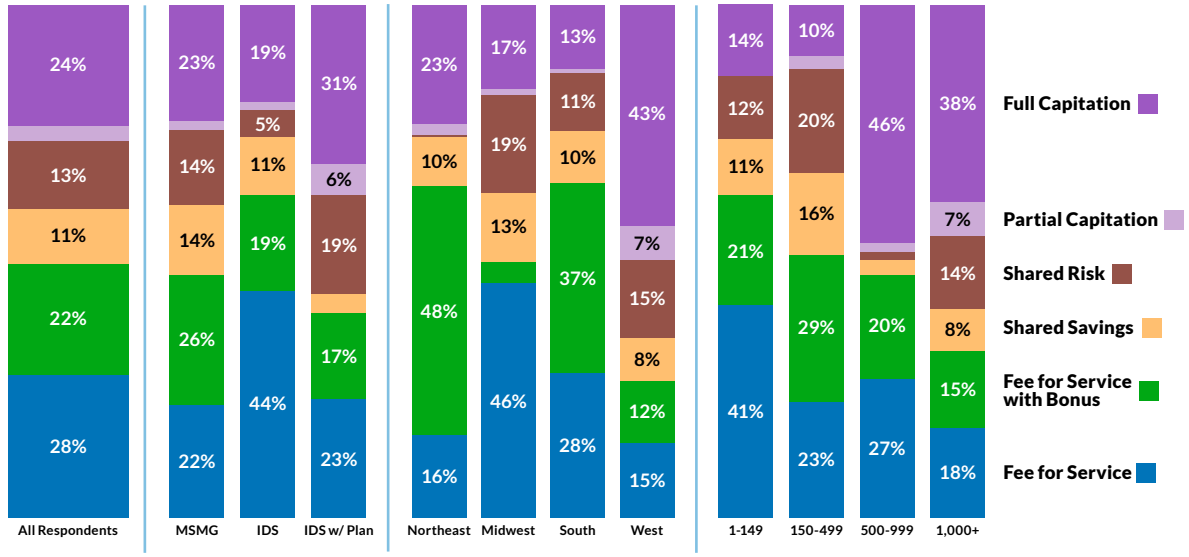
Beginning with Medicare Advantage, integrated medical groups have developed the skills and programs to successfully take on risk and to produce better quality health care with these new patient management tools.

The quantitative and qualitative components of the findings show that value-based care is building its stronghold in multispecialty medical groups. Participating organizations touted the use of new payment models and partnerships to expand the reach of value-based care arrangements to improve population health.

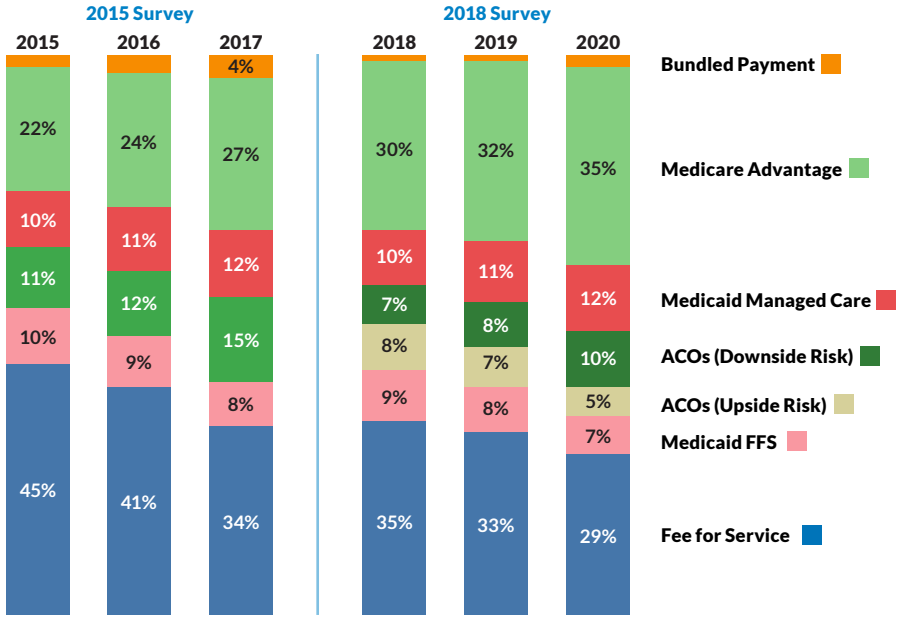
These multispecialty medical groups are expanding their engagement in performance-based risk contracting to deliver value-based care. As with past years, AMGA member groups continue to drive the transformation of healthcare delivery toward a model that offers high quality, coordinated care. Medical groups are increasingly confident that they will take up value-based arrangements as compared with prior years; they also identified areas where purchasers, payers and the federal government can work together to accelerate the transformation.

As a result, value-based care continues to grow in markets across the country, with new relationships and contracting vehicles spurring the adoption of performance-based risk. Medical groups are engaged in the daily work of redesigning payment and care delivery to improve outcomes for patients. 2020 is certain to bring with it expanded opportunities to drive this transformation.

Medicare Advantage (2018)



Revenue Sources: Federal 2015 vs. 2018



Charts from the AMGA 2019 Risk Survey

INTERVIEW PARTICIPANTS

Type of Organization Interviewed	#	Organizations Interviewed
Multispecialty medical groups	2	Everett Clinic Austin Clinic
Integrated delivery systems (IDS)	3	Northwell Health Ochsner Health Mayo Clinic
IDS with health plan	5	Marshfield Clinic Geisinger Health Sharp-Reese Stealy Northwest Permanente Medical Group Henry Ford Health System
Total interviews	10	

WHAT IS THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES?

The Council of Accountable Physician Practices, an affiliate of the AMGA Foundation, is a coalition of the nation's highest-performing medical groups and health systems. We believe we are better together. Our organizations are places where doctors from all disciplines practice together and learn from one another, backed by integrated services, systems, data, and technology. We recognize the importance of the patient-doctor relationship and know that, together, we can achieve the highest quality and ensure that patients come first.