



# COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES

An affiliate of the AMGA Foundation

---

## Moving the Needle on Value-Based Payment

### PART 3 OF IMPLEMENTING HEALTH SYSTEM IMPROVEMENT

---

#### PREAMBLE

During the 2016 election season, the Council of Accountable Physician Practices (CAPP) urged political candidates at all levels to focus on three critical health policy issues to support a better health care delivery system.<sup>1</sup> These issues should be at the top of every policymaker's healthcare agenda. They include:

- **IMPROVED AND HARMONIZED QUALITY MEASUREMENT AND REPORTING**
- **ROBUST AND COORDINATED USE OF HEALTH INFORMATION TECHNOLOGY**
- **VALUE-BASED PAYMENT**

In this brief, the third in a three-part series entitled "Implementing Health System Improvement," the physician leaders of CAPP provide more detailed insights and recommendations to elected officials, members of the administration, and other thought leaders about how to encourage the movement toward value-based payment.

---

#### KEY POINTS

- The predominant fee-for-service (FFS) healthcare payment system in the U.S. rewards volume over value, working against population health management and high-quality, coordinated care. Furthermore, restrictive FFS policies that dictate specific care-delivery processes and locations stifle delivery-system innovation.
- Value-based payment models, which include bundled payment, accountable care organizations (ACOs) and global capitation (among others), promote a focus on health outcomes and enable strong population health management.
- Despite some challenges, existing public- and private-sector value-based payment programs have helped doctors approach care in ways that simply are not possible under FFS. They have allowed physicians to focus their attention and creativity on the total cost of care for all patients as a population, while continuing to meet individual patients' needs.

- Policymakers must continue to support value-based payment programs. They can do so by: quickening the pace at which these programs are expanded; convening stakeholders to align bundled payment models; continuing to address attribution, data lags and other administrative issues in ACOs; focusing on two-sided risk models, including Medicare Advantage; helping consumers make informed choices of high-value providers; and remaining open to exploring the innovative ideas of stakeholders.

## INTRODUCTION

Health care is not a widget; it is not something that can be manufactured and purchased in discrete units. The achievement and maintenance of health is a complex, lifelong undertaking, carried out primarily by an individual with the support of his or her community, environment and health care delivery system. And yet, the large majority of the United States pays for health care as if it were a widget, through a fee-for-service (FFS) system that rewards providers simply for producing units of care (procedures, visits, prescriptions), whether they contribute to health or not.

In paying more for doing more, we reward volume rather than value in health care. Fortunately, there is significant momentum in the U.S. to shift our health care payment system away from the FFS model and toward an array of models that take a more holistic view of health care – collectively called “value-based payment.” These models, which include medical homes, bundled payment, accountable care organizations (ACOs) and global capitation, among many others, all place healthcare providers at some degree of financial risk for producing an outcome beyond simply delivering a service. Many such models encourage providers not only to care for individual patients, but also to consider the needs of entire populations (including those who do not seek medical care), to be wise stewards of resources and to invest in new ways to deliver care that is evidence-based as well as safer, more seamless and convenient for patients.

Today, delivery-system innovation has outpaced payment innovation. The transaction-based FFS system frequently provides no reimbursement for certain care modalities (such as telehealth) or care models (such as case management for high utilizers). In addition, purchasers using the FFS model often pay more for, and thereby encourage, treatment in more expensive sites of care (e.g., hospitals), even if lower-cost, safer options are available (e.g., patients’ homes, ambulatory surgery centers, etc.). When payers employ restrictive payment policies that dictate specific care-delivery processes or locations, they stifle delivery-system innovation. In contrast, value-based payment models give physicians, hospitals and other health care providers both incentive and latitude to invest in innovations that maximize health, rather than focusing solely on revenue generation.

Despite growing public- and private-sector commitment to value-based payment, FFS remains very much entrenched, accounting for an estimated two-thirds of all U.S. health care payments.<sup>2</sup> The persistence of FFS forces even the most forward-thinking health care providers to straddle two worlds: one in which they must continually do *more*, and one in which they are free to innovate to do *right*.

The members of the Council of Accountable Physician Practices believe the shift from volume- to value-based payment is critical to our ability to support patients in achieving health, and we ask policymakers to keep value-based payment at the top of their health policy agendas. We recognize that much of policymakers’ and the public’s attention is focused on potential changes to our systems of insurance coverage. While ensuring access to coverage is vital, the payment system

that underlies coverage is ultimately the strongest lever available for achieving the triple aim<sup>3</sup> of improving the individual experience of care, improving population health, and reducing per capita health care costs. Today's value-based payment models are not perfect, but they are a starting place.

In this brief, we outline our lessons learned from participating in certain value-based payment programs and suggest ways that policymakers can advance the pay-for-value movement.

## LESSONS LEARNED FROM VALUE-BASED PAYMENT TO DATE

As well-established and respected multispecialty group practices and integrated delivery systems, CAPP members have been regarded by many stakeholders as the organizations most likely to thrive under new value-based payment models. Indeed, many of our members have operated under such models for decades, and those that are newer to value-based payment have participated eagerly in more recent opportunities. Today's models, including bundled payments and ACOs, have enabled important innovations but have also come with challenges.

### ***The Challenges: Bundled Payment and ACOs***

Many of the CAPP members have participated in bundled-payment programs initiated by public and private payers. We support the use of this payment model when appropriate – specifically, for patients requiring well-defined, time-limited episodes of care or procedures. When organized around such episodes or procedures (for example, joint replacement or treatment of acute myocardial infarction), bundles encourage providers to manage each episode in the most efficient way. They do not, however, encourage providers to consider whether a given procedure or treatment is needed at all, as the bundle only becomes available once the need for the procedure/treatment is clearly established. For this reason, bundles are not an ideal payment mechanism for care that is both complex and ongoing – for example, for the management of chronic disease, where the best care may obviate the need for a procedure or treatment, and where the timeframe in which care delivery should be “complete” is open-ended.

In contrast, ACO payment models put providers at risk for meeting budget and quality targets for whole populations, rather than solely for those needing specific types of care. As a result, ACOs may be more appropriate than bundles for caring for patients with chronic disease and for keeping healthy patients from becoming sick. CAPP members have participated in a plethora of Medicare, Medicaid and private ACOs. While we see great potential in these models, we have been challenged by several issues, including patient attribution methods, data lags and, in some cases, unrealistic financial models using historic cost trends that ultimately penalize us for previous efficiencies.

Under many models, we are not certain at the start of the performance measurement period which patients will be considered our responsibility. If we do not know who our patients are in advance, we cannot proactively reach out to them for prevention and disease management. A related issue is that patients who are attributed to us are free to seek care from any providers they choose, challenging our ability to manage and coordinate their care. For ACOs to make a real and sustained difference in care delivery, both patient and provider must have a mutually acknowledged responsibility to one another, and that acknowledgment must come at the start of the performance period. Further, payers often do not provide us with timely performance and cost data. With the shifting attribution of patients year to year, feedback may come too late, as groups of patients may be attributed to another provider by the time we receive information about their care.

### ***The Opportunity: A Shift in Thinking***

Despite the challenges we have experienced under specific value-based payment programs, these models have been immensely valuable for one important reason; simply put, value-based payment changes the way doctors think. A common experience shared by many of the CAPP members – whether they have operated under value-based payment for decades or just a few years – is that these models allow us to approach care in ways that simply are not possible under FFS. They allow us to focus our attention and creativity on the ***total cost of care for all of our patients over time and as a population***. “Total cost of care” is a concept that encompasses not only the unit costs of specific services but also volume of care; to ensure quality, safety, efficiency and convenience for all, we must consider both.

A mindset focused on total cost requires us to redesign care around patients, to provide the best value for them by improving the efficiency of all of our processes. By partnering with payers under value-based payment, physician groups have gained access to data – many of them for the first time – that allow them to identify patterns of care and their cost and quality impact. Everything then becomes fair game for improvement – from reducing unnecessary imaging, to improving laboratory throughput; from improving rates of preventive care, to helping patients stay on needed medications; from keeping facilities open at times most convenient for patients, to providing telehealth tools that allow patients to obtain care with less disruption to their lives. This holistic view of health care delivery becomes possible when providers are no longer paid for widgets, but rather for integrated health care services that align with good outcomes at lower cost.

### **A CALL TO ACTION: POLICYMAKERS’ ROLE**

The public sector has made tremendous strides in the last few years in promoting value-based payment. Our own patients have benefitted from the innovation that comes from early adoption of these models. We would like to see all patients across the country benefit similarly. Accordingly, we urge policymakers not only to persevere with value-based payment programs, but to quicken the pace of their introduction and proliferation. We offer several specific recommendations.

#### ***Keep moving forward.***

With or without public-policy support, we believe private payers will continue to push for value-based payment models – including global capitation – that place more and more financial risk on providers. We support global capitation with quality measurement as an ideal form of value-based payment but recognize that it requires a certain size, as well as a set of care- and financial-management competencies that many providers do not yet have. Despite some challenges, the many value-based payment programs sponsored by the Centers for Medicare and Medicaid Services (CMS) are critical because they allow providers to adopt models that are appropriate to their size and experience and to start learning to redesign care, without having to jump into risk-bearing models for which they are not prepared. CMS’ commitment to a variety of value-based payment models gives providers a glide path of steps they can take to change the way they deliver care. Accordingly, we are concerned about any signals from CMS or policymakers that make the glide path less clear, such as recent decisions to pull back from certain Medicare bundled-payment programs or to delay the timeline for using the cost portion of Medicare’s Merit-Based Incentive Payment System (MIPS). Such decisions move value-based payment and care redesign in the wrong direction.

***Address challenges in the ACO programs.***

We enumerated several challenges we have experienced under ACO programs. For those of us now participating in the more advanced public ACO models, including the Next Generation program, some of these challenges have been mitigated. For example, some have found that data turnaround time and attribution accuracy are much improved. We commend CMS for listening to providers and continuously improving these programs. We believe that it will ultimately be important for providers to move into ACO models with at least some down-side risk, which provide greater incentive and more resources to invest in innovation. To that end, we would like to see CMS pay particular attention to addressing providers' concerns about the two-sided risk models.

***Help coordinate bundled payment programs.***

One of the greatest challenges we face under bundled payment programs is a lack of coordination among purchasers, leading to significant administrative complexity for providers. For example, multiple payers may offer a bundle for joint replacement, but the specifications for starting and ending the bundle may be different, as may be the scope of services included. In some cases, a single payer may offer multiple bundles that either overlap or interact poorly with one another. Acting as a facilitator, CMS or another appropriate federal agency could bring together stakeholders to agree on a limited set of high-priority bundles and drive toward agreement on specifications. With such streamlining and simplification, we believe many more providers would choose to participate in bundles. We also believe that an inclusive stakeholder-driven process would lead to the use of broader outcomes measures in bundled-payment programs, including patient-focused outcomes, such as pain reduction and time required to return to normal activities of daily living.

***Continue to support and grow Medicare Advantage.***

While not considered one of the "new" payment models, Medicare Advantage (MA) is indeed value-based, with health plans receiving global capitation payments from Medicare. Today, fully one-third of Medicare beneficiaries, or 19 million people, are enrolled in Medicare Advantage.<sup>4</sup> Of those, nearly 63 percent, or 11.9 million beneficiaries, participate in MA Health Maintenance Organization (HMOs), many of which, in turn, capitate their partner provider groups (a practice we encourage). Medicare Advantage is popular with beneficiaries<sup>5</sup> and has broad, bipartisan support among policymakers. Further, MA plans perform better than FFS Medicare on several important measures of quality.<sup>6</sup> Most of the CAPP members have at least some capitated HMO patients under MA, and we consider the program critical to our ability to innovate for greater value, efficiency, and convenience. We therefore urge policymakers to continue to support, and even expand, MA. We are also concerned that many of the proponents of "Medicare for All," may be leaving MA out of the discussion. It is vital that if Medicare is expanded, MA expands with it; to expand only the FFS side of Medicare would be to encourage greater fragmentation and lack of coordination in the delivery system, undoing much of the progress made under value-based payments.

***Help make it easier for patients to choose high-value providers.***

As discussed above, the success of many value-based payment programs depends on both providers and patients mutually acknowledging their commitment to one another. It is difficult, for example, for providers to invest in preventive-care improvements if they experience significant movement of patients to other providers ("churn"). One study found the annual ACO patient churn rate to be as high as one-third.<sup>7</sup> Of course, we recognize that, to a large extent, the onus of convincing a patient to remain with a given provider group or system from visit to visit (or year

to year) is on the provider. In particular, with out-of-pocket cost-sharing on the rise, it is more incumbent upon providers than ever before to demonstrate their value to patients. While providers must do better in this area, policymakers can help create an environment that is more conducive to patients making informed choices about provider groups and systems. For example, Medicare could give (or allow ACOs to give) beneficiaries a financial incentives to obtain care from groups or systems performing well under ACO programs; similar incentives could also reward the choice to remain with a high-performing group in each subsequent year, or to limit care for a specific period of time to a given high-performing group.

***Allow and encourage payment experimentation.***

There is no single value-based payment program that works perfectly for all providers, all patient populations, and all types of care. Accordingly, payers and providers must continue to experiment with these systems and remain flexible to try new and different models. Government, in its role as both purchaser and influencer, must encourage experimentation, with appropriate guardrails to protect patients. We ask policymakers to keep talking and listening to stakeholders who are exploring a variety of worthwhile ideas, such as expanding payment for telehealth and in-home care, implementing value-based insurance design, supporting dedicated care management for the highest-utilizers, and many more. We commend Congress' recent passage of the CHRONIC Care Act (as part of the 2018 Bipartisan Budget Act), which supports many of these initiatives. Going forward, we ask CMS and Congress to remain open to partnering with providers, private payers, states and patients in new ways, providing more opportunities for the testing of innovative payment programs that enhance health care value.

---

## **WHAT IS THE COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES?**

**The Council of Accountable Physician Practices** 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.

---

## **ENDNOTES**

- 1 Council of Accountable Physician Practices. *What Every Candidate Should Know About Health Care*. 2017. Available at: [http://accountablecaredoctors.org/wp-content/uploads/2017/08/capp\\_candidateprimer\\_2017.pdf](http://accountablecaredoctors.org/wp-content/uploads/2017/08/capp_candidateprimer_2017.pdf).
- 2 Health Care Payment Learning and Action Network. *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs*. October 2016. Available at: <https://hcp-lan.org/2016/10/u-s-health-care-system-is-progressing-in-the-adoption-of-alternative-payment-models-that-promote-quality-and-value/>.

- 3 Berwick, D., Nolan, T.W., Whittington, J. The Triple Aim: Care, Health, and Cost. *Health Affairs*, vol. 27 no. 3 (2008), pp: 759-769.
- 4 Jacobson, G., Damico, A., Neuman, T., and Gold, M. *Medicare Advantage 2017 Spotlight: Enrollment Market Update*. Kaiser Family Foundation Issue Brief. June 2017. Available at: [www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/](http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/).
- 5 McCarthy, M. Seniors Love their Medicare (Advantage). *Morning Consult*, March 2015. Available at: <https://morningconsult.com/2015/03/30/seniors-love-their-medicare-advantage/>.
- 6 America's Health Insurance Plans. *Medicare Advantage: Providing High-Quality Care to Medicare Beneficiaries*. November 2016. Available at: [www.ahip.org/wp-content/uploads/2016/05/MAHighQuality\\_5-16-16.pdf](http://www.ahip.org/wp-content/uploads/2016/05/MAHighQuality_5-16-16.pdf).
- 7 L&M Policy Research. *Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings from Performance Years One and Two*. March 10, 2015. Available at: <https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>.