

## Should We Accelerate the Adoption of Value-Based Care?

### Key Takeaways:

There is bipartisan support for moving the healthcare system away from volume and towards value. However, payment innovation lags behind delivery system innovation.

While HHS has mixed messages related to its support for value-based care (VBC), the current environment indicates that CMS is promoting new, mandatory VBC models to speed up VBC adoption and the move towards downside risk.

Providers and hospitals are less enthusiastic about pushing forward with models that include downside risk as they continue to struggle with the infrastructure needed for that transition; current data, payment, and care management systems do not support the status quo of fee-for-service and VBC simultaneously.

Provider organizations believe that pushing providers to take on more risk before they have the systems set up to manage value-based payment will cause a backlash and fewer providers to risk.

### Introduction

While we still lack a common definition of “value,” the industry generally agrees that physician payment incentives should align to promote higher quality and reduce costs. Value-based payments, which includes bundled payments, accountable care organizations (ACOs), and global capitation, among others, financially reward providers for improved patient outcomes and encourage population management. These payment systems remove most of the incentives established under fee-for-service to provide quality care to patients who need it. There is bipartisan support for value-based care (VBC) programs and accelerating their adoption, yet only 14 percent of Medicare providers participate in value-based arrangements. Under the Trump administration, CMS initially signaled a slowdown in the spread of VBC by canceling several mandatory programs. With a shift in Health and Human Services (HHS) leadership to Alex Azar, CMS has reinstated those

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programs and is pushing for broader adoption: CMS has announced new programs promoting VBC, such as developing templates for states to more easily spread these new payment models to Medicaid. Indeed, as HHS Secretary, Alex Azar has stated that moving the system to paying for value rather than volume is one of his top four priorities [1].

Despite the federal focus on VBC, momentum is growing slowly, with an estimated 4 percent annual increase in value-based payments. The Healthcare Payment Learning & Action Network (LAN) estimates that about one-third of payments were tied to an alternative payment model in 2016. The outcomes, however, are murky and have not made a market-wide impact on cost or quality yet. A recent study supported by the Commonwealth Fund analyzing Medicare and commercial data in more than 900 markets across the U.S found that the penetration of value-based payment models has not made an impact on reducing market-level growth of total costs of care [2]. Fee-for-service payment remains the underlying payment mechanism for many of these initial value-based care models, particularly retrospective payment models.

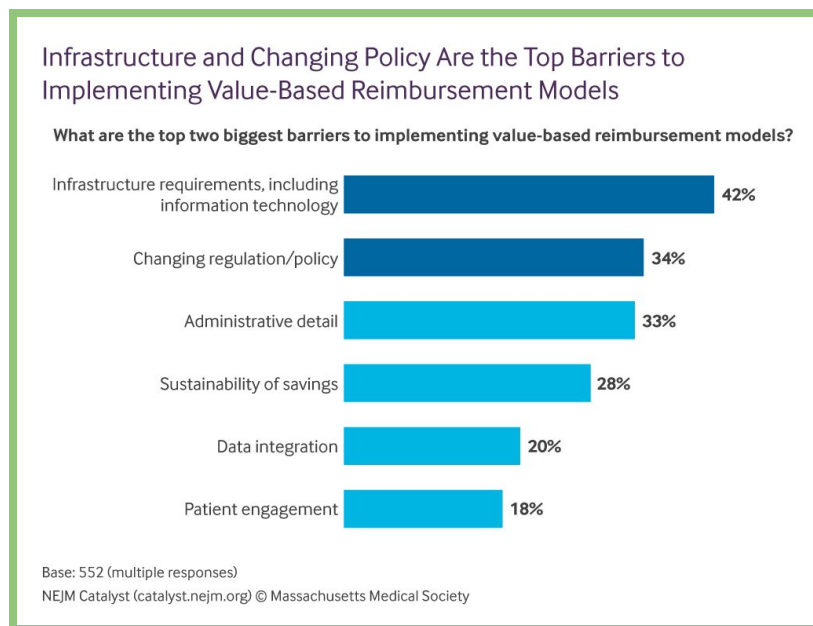
## **Changes in Regulation and Incentives**

The recent Medicare Access and CHIP Reauthorization Act (MACRA) passed in 2015 is unlikely to catalyze a major transition to VBC [3]. Replacing the Sustainable Growth Rate (SGR) payment system with MACRA was intended to incentivize a move toward value with the new Quality Payment Program. Medicare providers were offered two tracks: the Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs). Due to the complexity of the MIPS system and its inability to distinguish high-performing from low-performing providers, its impact on patient care is unclear. The Medicare Payment Advisory Commission (MedPAC) recently recommended scrapping MIPS entirely and replacing it with a voluntary program. For providers who choose the APM track, they are limited to participation in only CMS-approved initiatives. Of the 13 advanced APMs, eight are specific to individual states or to specific disease-states, leaving providers with few options of models to pursue within Medicare [4].

## **Current Challenges**

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There remain significant challenges to the broader adoption of these payment models. Often the financial incentives behind fee-for-service (FFS) are in direct conflict with VBC and so in the short-term, the transition from FFS to value-based payment can represent a reduction in profits [5]. This mismatch, not only in financial incentives but in the underlying claims payment infrastructure, can make the transition extremely painful for providers. Providers want incremental transitions to dabble in VBC before making a full transition, yet this results in different standards of care for patients based on the payer or payment contract [6]. ACOs in particular are challenging for providers when the population of patients attributed to the ACO is unclear or patients are free to seek care elsewhere, negating the intended purpose of the ACO to manage all of the care for that specific patient. Long delays in performance data from payers makes it difficult to assess the impact of changes to care processes as well.



## The Argument For Accelerating VBC

Supporters of accelerating VBC point to the successes from different models implemented around the country. Based on its own internal study, Humana found that patients in its Medicare Advantage plans, a value-based insurance offering utilizing capitated payments that is regulated by the Centers for Medicare and Medicaid services, had medical costs

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15.6 percent lower than fee-for-service patients and 7 percent lower emergency room visits [7]. Prospective bundled payment programs have demonstrated superior outcomes and lower costs for acute, episodic surgical care such as joint replacements and bariatric surgery [8]. These models are delivering the type of results in terms of lower cost and higher quality that the healthcare system needs, and yet the pace of adoption is not delivering market-wide results [2]. A New England Journal of Medicine survey found that value-based reimbursement comprises only 25 percent of provider revenues [9]. Supporters of accelerating the move to full risk believe that providers need additional incentives to realize the benefits of value-based payment on a broader scale.

## **Make Participation Mandatory**

CMS is taking actions to accelerate VBP through mandatory programs, with an upcoming mandatory radiation oncology model announced at the end of 2018 as well as re-visiting two voluntary cardiac models. In late 2018, CMS also finalized an overhaul of the Medicare Shared Savings Program (MSSP), the program under which most Medicare ACOs operate, renaming it “Pathways to Success.” As originally designed, the program was not successful at lowering costs and actually increased net spending, likely because 82 percent of the ACOs participating in the program were not at risk for additional costs. The structure of the program has not incentivized providers to move quickly enough to fully embrace VBC, and so the revamped program decreases the amount of time new ACOs can remain in a one-sided risk arrangement from six to two years. Launching later this year, the program aims to accelerate the number of ACOs taking on down-side risk and with the hope of realizing cost savings. The current HHS Secretary has indicated that mandatory models are the only way to collect enough information to determine whether a new model is successful at reducing costs and improving quality [10]. Organizations like the Healthcare Transformation Task Force (HCTTF) welcomed the proposed change as a necessary step to promote VBC transformation and accelerate industry momentum towards wide-spread VBC adoption [11].

“In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us.”

- Alex Azar, HHS Secretary

## **Foster Innovation**

VBC can take many forms and needs to consider local healthcare landscapes. New policy is enabling providers the flexibility to provide comprehensive care in new ways: The CHRONIC Care Act of 2017, which expands options for in-home care and tailoring programs to meet the needs of specific patient populations, is an example of recent legislation that gives providers the leeway to decide what is best for their patients. Providers are also demonstrating an eagerness for progressing VBC within their own specialties and expanding the suite of APMs [4]. Leading urologists around the country, in conjunction with the practice association, developed their own urology APMs. One of the key considerations was how to reduce barriers to adoption and so the APM included monthly fees to support practice transformation. If approved, this could encourage other provider specialties to take charge and support their own APM development process.

## **The Case for a More Gradual Approach to VBC Transition**

For providers that are exploring VBC for the first time, gradual pathways are needed to help providers make these investments and adjustments in a realistic timeframe. For some of the voluntary Medicare programs, like the newly renamed MSSP, providers that are not ready to take on financial risk and are forced to transition too quickly are at risk of leaving those programs and halting progress towards more widespread VBC [12]. The National Association of ACOs (NAACOs) and American Hospital Association (AHA) are concerned that such a mandatory shift to take on downside risk after only two years of program participation would harm existing ACOs and even reverse progress [13]. A NAACOs survey found that slightly over 70 percent of MSSP ACOs would leave the program rather than assume downside risk [14]. Uncertainty in Washington and the mixed messages that come from canceling and then reinstating VBC programs means hospitals are not going to dive in head first with these types of contracts [15]. An American Academy of Family Physicians and Humana physician study found that 62 percent of physicians remain skeptical about VBC models, citing that there is a lack of evidence that using performance measures results in better patient care [16]. For proponents of a more gradual approach for adopting VBC,

physicians have to be on board with these new models in order for them to be successful and that is not currently the case.

### **Lagging Infrastructure and Data Reporting**

Providers are fully responsible for investing in the systems and people to change the way they are delivering care in order to meet VBC requirements. As a result of this overhaul to the status quo, providers cannot be expected to make this change overnight. Smaller, physician-led organizations are at a disadvantage during this shift and may not have access to the capital needed for investments in IT, population health management, and care management that are critical for success under new payment models. A 2018 Deloitte survey of physicians found that 72 percent of physicians indicated that some type of cost information would be useful at the point of care, but only 28 percent receive cost information, such as resource use for their attributed patients, for physicians or facilities they refer to, or estimated patient out-of-pocket costs [17]. Without this type of information, providers may struggle to make data-driven decisions under value-based contracts. This information also takes time and education to incorporate into daily practice.

The current design of ACO models does not set up providers for success. In addition to the lag in cost and performance data, the ACO patient attribution model retains patient choice of participation, but still keeps providers on the hook for care outside of their oversight or control. Additionally, the annual churn rate for an ACO can be as high as a third of all patients [5]. If the current models, including MSSP, do not provide incentives for patients to keep care within the ACO they are assigned to, providers are going to remain hesitant about participating when the deck is stacked against them. Financial incentives for seeking out high-value care could help resolve this issue.

### **Administrative Burden**

While Medicare has its own set of value-based payment models, commercial payers have followed suit, with payers developing their own alternative payment contracts with providers. The plethora of payment options, and therefore payment and performance requirements, creates additional administrative complexities for providers and is a barrier to providers signing more VBC contracts. It exacerbates the issue of having one provider's

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patients falling within multiple different care guidelines. Before CMS broadly mandates participation in its APM models, there needs to be a simplification of the measurement and administration of several value-based payment models to avoid further burdening providers with overwhelming administrative costs.

## **Scope Creep of Providers' Role**

As new value-based payment models put providers on the hook for the whole care of a patient, they are being asked to address and consider social determinants of health and the integration with other social services. While this shift is important to getting patients the support they need, scarce resources and inadequate data make this a daunting task to put on providers alone [15]. Stronger partnerships with community organizations is important, but it is the role of the broader social safety net to provide services outside of direct healthcare provision.

## **Conclusion**

Providers, payers, patients, and policy-makers agree that VBC is necessary to re-align incentives to keep people healthy. The up-front investment needed to adapt payment and care systems so that providers can successfully implement value-based payment is slowing down the movement away from FFS. For those that support accelerated adoption of VBC, policy mechanisms such as mandatory participation in CMS's APM programs, shortened time-frames to take on additional risk, and rewarding providers for innovation could help ease the transition. Supporters of a slower adoption of VBC argue that pushing providers too soon to take on risk without the right supports in place, however, could halt further expansion beyond mandatory programs if providers cannot successfully operate under value-based payment models.

### **Discussion Questions**

Is there genuine consensus that value-based care is the optimal way to pay for healthcare?

Is the system ready for mandatory adoption of downside risk?

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If value-based care is as important as many believe, why has adoption of it been so limited?

What policy solutions should be considered to accelerate the adoption of value-based payment models?

Would mandatory adoption of a value-based care regime harmfully disrupt provider systems' existing financial models?



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