



Health Program

Health Project

Transitioning from Volume to Value:

Opportunities and Challenges for Health Care Delivery System Reform

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BIPARTISAN POLICY CENTER



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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

DISCLAIMER

This report is the product of the BPC Health Project with participants of diverse expertise and affiliations, addressing many complex and contentious topics. It is inevitable that arriving at a consensus document in these circumstances entailed compromises. Accordingly, it should not be assumed that every member is entirely satisfied with every formulation in this document, or even that all participants would agree with any given recommendation if it were taken in isolation. Rather, this group reached consensus on these recommendations as a package.

The findings and recommendations expressed herein are solely those of the commission and do not necessarily represent the views or opinions of the Bipartisan Policy Center, its founders, or its Board of Directors.

DELIVERY SYSTEM REFORM INITIATIVE

In April of 2013, BPC issued *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, a report which laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs – former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ways and Means Health Subcommittee Chair Jim McCrery – are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

AUTHORS

This paper was produced by BPC staff in collaboration with a distinguished group of senior advisors for the Delivery System Reform Initiative. BPC would like to thank Sheila Burke, Stuart Butler, Paul Ginsburg, Chris Jennings, Steve Lieberman, and Tim Westmoreland for providing substantial direction and support, and acknowledge BPC staffers Katherine Hayes, Leah Ralph, Brian Collins, Katie Golden, Marisa Workman, and Katie Taylor for their role in researching and drafting the final paper.

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Introduction

In early 2014, the Bipartisan Policy Center's Health Project began discussions with a diverse set of health care experts and stakeholders on issues related to physician payment reform and transitioning to alternative systems of payment and delivery. In the coming months, the Bipartisan Policy Center (BPC) will issue a series of white papers, drawing from those discussions and other resources, to offer legislative and regulatory policy recommendations on the implementation and acceleration of delivery system and payment reforms. As the first in this series, this paper identifies opportunities and challenges in the transition to organized systems of care through the lens of the current legislative and regulatory environment. This includes pending Medicare physician payment legislation as well as a discussion of the primary alternative models of health care delivery.

Background

In April 2013, BPC's Health and Economic Policy Projects collaborated to produce a comprehensive solution to improve quality and value in the U.S. health care system. The report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, was based on the growing consensus that the current fee-for-service (FFS) payment system inherently rewards volume and drives excessive utilization. Health care providers seeking to improve population health by coordinating care, providing appropriate services, and improving the overall quality of care are often penalized under the current FFS structure because many services used to improve care are inadequately rewarded, and accompanying decreases in volume result in lower revenues. BPC's 2013 recommendations centered around delivery system reforms designed to incentivize health care providers and patients to transition from the current volume-driven FFS system to organized systems of care, as well as reforms that would improve Medicare Advantage with competitive pricing, and modernize the Medicare benefit.

While BPC's leaders¹ continue to support and remain committed to the broad range of policies advanced in *A Bipartisan Rx*, the report was conceived in an environment of impending budget sequestration and the possibility of bipartisan compromise on deficit reduction, or a so-called "grand bargain." Since that time, the political environment has shifted, and prospects for comprehensive changes in the near-term are dim. Although there will be limited opportunities for legislative action in the coming year, it is still possible to advance the goals of improving quality and value in the health care system through the enactment and implementation of bipartisan physician payment reforms and regulatory changes in the structure of existing alternative systems of care.

Opportunities for Reform in the Near-term

Over the next year, opportunities to promote improved alternatives to the current FFS reimbursement system will likely be limited to two options. First, Congress will likely address Medicare physician payment reform, which is necessary to avoid a 20.9 percent payment cut in 2015. Second, there will be opportunities through regulatory action by the Centers for Medicare and Medicaid Services (CMS) related to transitioning to organized systems of care, which are the basis for the alternative payment models described in pending Medicare physician payment legislation and thus integral to implementation of the legislation.

Physician Payment Reform

Earlier this year, the three congressional committees of jurisdiction—the Senate Finance Committee, House Ways and Means Committee, and House Energy and Commerce Committee—reached agreement on the core elements of legislation to replace the Medicare sustainable growth rate (SGR) physician payment system (referred to here as the “tri-committee” bill).² The tri-committee bill links payment updates for physicians to participation in alternative payment models (APMs) that require physicians to assume some financial risk for the patients they serve, with the goal of improving quality and value of care. The legislation creates a two-track payment system, retaining a modified FFS system with a value-based incentive structure and providing incentives for providers to participate in APMs in the form of bonuses and higher payment updates. Several fundamental elements to physician payment reform employed in the tri-committee bill are consistent with BPC’s approach and other major payment reform proposals. While there is agreement on the tri-committee bill, Congress has been unable to pass the legislation because of disputes over how to offset its cost.³ We believe that costs associated with this approach should be fully offset in a thoughtful way that can garner bipartisan support. Currently, it is unclear whether the legislation will pass this year, will be delayed until next year, or if yet another temporary “patch” to prevent Medicare payment cuts must be enacted first. Nevertheless the bipartisan, bicameral consensus achieved in each of the committees—and ultimately across committees—points in the direction of payment reforms for physicians that might be politically feasible.

Regulatory Action on Alternative Systems of Care

Once the law is enacted, CMS faces a considerable task in implementing physician payment reform. A critical component of the success or failure of the law depends on the status of a number of alternative systems of care currently underway. The CMS Center for Medicare and Medicaid Innovation (CMMI) continues to develop and test innovative care models, some of which are critical to the success of physician payment reform. Many, if not most, of the opportunities and challenges outlined below are relevant to both physician payment reform and overall delivery system reform, which goes beyond physician-only models and includes the full range of providers and payers, including hospitals, post-acute care, non-physician practitioners, and private health insurers.

Alternative Systems of Care: Three Major Structures

In an effort to frame future discussions around physician payment reform and alternative systems of care, it is useful to define the key goals and characteristics of those models. Alternative systems of care, as we know them today, fall into three general structures: bundled payments, patient-centered medical homes (PCMHs), and accountable care organizations (ACOs). While differing in scope and design, all three of these models are designed to improve quality and value, leading to better care and lower health care costs.

Bundled Payments

Under bundled payments, providers are paid on the basis of a spending benchmark per episode of care. An important challenge with structuring bundles has been designing coherent, robust bundles that are meaningful while also avoiding inadvertently stimulating additional episodes. As we look ahead at how to expand the role of bundled payments in the movement toward alternative systems of care, BPC will explore how to best transition from independent arrangements toward episodes that most appropriately improve the efficiency and quality of our health care system.

Patient-Centered Medical Homes

The patient-centered medical home (PCMH) is another widely implemented alternative care model. PCMHs emphasize integrated care in which primary care physicians coordinate care, educate patients, and provide additional services not paid for under FFS. PCMH models are currently operating through private organizations, Medicaid waivers, and several CMMI models including the Federally Qualified Health Center's Advanced Primary Care Practice demonstration, and several Health Care Innovation Awards and State Innovation Models. PCMHs typically include an additional payment per beneficiary per month that supplements FFS payment. While the approach may be an appropriate first step toward alternative systems of care, there are opportunities for improvement within PCMH design and payment to allow it to continue to evolve toward a risk-bearing entity. In a future paper, BPC will examine PCMH model designs that promote increased provider participation while rewarding the uptake of one-sided risk, allowing the PCMH to share in the savings but not in the losses.

Accountable Care Organizations

Accountable care organizations (ACOs), which have received substantial attention from policymakers, payers, and providers, are health care provider organizations that agree to provide coordinated care to a defined patient population with shared incentives based on a benchmark of spending per attributed beneficiary. CMS is testing this model with the Medicare Shared Savings Program (MSSP) and two related CMMI models known as the Pioneer ACO and Advance Payment ACO models, in which Medicare providers are eligible for bonus payments on top of existing FFS payments if they can hit certain spending, quality, and patient-satisfaction targets. Currently, there are 338 MSSP participants, more than 200 ACO arrangements with private payers, and just over 70 ACOs with both government and commercial contracts across the country.⁴

While the Medicare ACO programs represent a start toward meaningful payment reform, many are not achieving early cost savings, and critical improvements to ACOs are needed for these models to be successful and sustainable, including stronger incentives for providers to participate, more accurate attribution of beneficiaries, revamped quality measures, and better tools to engage patients in their care. In a June 2014 letter to CMS, the Medicare Payment Advisory Commission (MedPAC) made a number of recommendations for suggested changes to the current Medicare ACO model and identified barriers to optimal operation, including the need for prospective beneficiary attribution and financial benchmarks, movement toward a small number of outcomes-based quality measures, provision of regulatory relief as an incentive for ACOs to move to two-sided risk, and stronger tools to encourage beneficiary engagement, including relaxed cost-sharing requirements and a streamlined process for CMS review of marketing materials.⁵ Variations of many of these recommendations were also included in BPC's April 2013 *Bipartisan Rx* report. BPC will explore these and additional operational challenges with the ACO model in a subsequent white paper.

Key Challenges and Opportunities in Payment Reform: Alternative Systems of Care and Delivery System Reform

The success of these models, and a reformed delivery system that rewards quality and value, will principally rely on widespread participation among providers, strong engagement of beneficiaries, carefully constructed and appropriate measures—including quality measurements and financial benchmarks—and, in the long-term, providers taking two-sided risk (both bonuses and penalties). We also recognize that no single model is necessarily the best or most efficient for a geographically diverse, heterogeneous population.

Among the challenges that must be addressed by CMS to assure a successful transition to alternative systems of care:

- **Improving quality while also slowing the rate of health care cost growth.** Alternative systems of care must aim to improve quality while remaining less costly than the current FFS system.
- **Widespread provider participation.** Achieving new systems of care will require widespread provider participation in alternative systems of care, and shifting large numbers of physicians and other providers toward unfamiliar models with new cost and quality requirements will require strong incentives. As proposed in BPC's and similar delivery system reform proposals, differential updates are critical mechanisms to achieving this movement. The tri-committee bill took an important step in this direction by offering higher payment rates for physicians participating in APMs. Specifically, the legislation proposes that, starting in 2024 and after a transition period, providers participating in APMs receive annual updates of 1 percent, while other providers receive annual updates of 0.5 percent.⁶ The legislation also provides for bonus payments, proposing that from 2018 through 2023, providers who receive a significant portion of their revenue from an APM are eligible to receive a 5 percent bonus. BPC's *A Bipartisan Rx* recommended a more aggressive differential,⁷

proposing that for ten years payment updates would only be available for providers, including hospitals and post-acute care providers, who belong to or contract with a “Medicare Network,” BPC’s version of an enhanced ACO model.⁸

- **Structuring incentives to incorporate the full range of providers, not just physicians.** Beyond differential updates, policymakers must ensure that alternative systems of care are structured to provide meaningful opportunities for a range of practitioners to participate, including physicians and advanced practice nurses, those in primary care and in specialties, and hospitals, ambulatory surgical centers, and post-acute care. Specialists in particular face significant barriers to participation in payment models currently being tested at CMS. The participation and investment of the medical community in these models are critical to their success and sustainability.
- **Facilitating the establishment of alternative systems of care in rural areas.** There is considerable difference of opinion among policymakers as to whether the ACO model is viable in rural and frontier areas. While some argue that current referral patterns can serve as a basis for risk-based relationships, others argue that the low volume of patients will not permit two-sided risk. Providers in rural areas, for example, may have far fewer resources, less access to data infrastructure and new technology, and limited ability to partner with larger organizations for assistance with clinical integration, claims processing, or other administrative support. Smaller, rural practices may be more likely to participate successfully if urban systems have the potential, and interest, to include rural physicians and other providers in their new models of care.
- **Structuring new models to best engage and pay specialists.** Policymakers continue to seek models that appropriately integrate specialty care. As currently structured, ACOs have not included physicians in many specialties as members of the organization, even if the primary care physician members are steering referrals to the higher-value specialists. Although CMMI is expected to pursue some additional models that are relevant to other specialties, to date, bundled payment initiatives have been limited to inpatient orthopedic and cardiac procedures.
- **Improved beneficiary engagement and attribution.** Policymakers continue to debate how to structure beneficiary information and incentives to encourage enrollment in enhanced ACOs, affiliation with primary care clinicians in a medical home, or the favoring of “in network” practitioners. Currently, Medicare beneficiaries have little incentive to seek care from providers in a specific ACO because they usually do not know they have been attributed to an ACO and have little to no understanding of the goals of ACOs or how belonging to one could improve their health or lower their spending. For a provider organization to effectively coordinate care and manage chronic diseases, beneficiaries must be aware that the organization exists, and incentives must be structured to encourage beneficiaries to favor the organization’s network of providers.

- **Improved, streamlined quality measures.** Developing a limited and universal set of quality measures that is meaningful for the purposes of determining quality and payment has been a longstanding challenge for policymakers. A key criticism of public and private payers is the variety, complexity, and sheer number of quality measures. For the success of alternative systems of care, quality measures must be reviewed for consolidation and appropriateness.
- **Timely, useful performance and benchmark data to providers.** A frequent complaint of those participating in Medicare ACOs is the inability to get timely feedback on care being delivered to attributed beneficiaries by both ACO and non-ACO providers. We understand that CMS is working to address this issue in a forthcoming ACO rule.
- **Transparency in price and quality to assist beneficiaries in making meaningful choices about providers.** In an era of increasing out-of-pocket costs for insured individuals, consumers need to be able to obtain the appropriate information to allow them to make rational decisions about price and quality of care. Appropriate quality measures reflecting patient-reported outcomes and patient experience should be a means of providing the beneficiary with meaningful information to make decisions about their care.
- **Adequate technical assistance.** CMS needs to ensure the technical assistance currently available to providers through the learning collaboratives is sufficient to aid the creation and/or expansion of alternative systems of care, as well as improve their operations and performance.
- **Determining if and when health information technology can be fully interoperable.** Health care plans and providers continue to struggle with electronic health records that do not permit, much less facilitate, the flow of data necessary to quickly identify outliers and intervene to change provider behavior, as well as obtain patient information consistently.
- **Determining the impact of market consolidation.** To ensure that increasing market share does not result in driving up prices, it is necessary to investigate where the consolidation of providers improves quality and value.
- **Determining the appropriate role of telemedicine.** The appropriate use of telemedicine is key to evolving alternative systems of care that improve quality and value. Telemedicine coverage might be limited to risk-bearing organizations as an incentive to provider and beneficiary engagement, and/or services could be made more broadly available to improve care in medically underserved areas.
- **Assuring critical mass.** Models could be better structured to ensure parallel activities by private insurers and self-funded employers so that a sufficient percentage of beneficiaries are enrolled in alternative systems of care to make the models financially viable. Those who have successfully operated ACOs and other

alternative systems of care have noted the difficulty in making investments and changing medical practice based on a small percentage of patients. In many cases, providers who change the way they practice for all patients will not receive incentive payments for those who remain in FFS. Some experts have indicated that unless at least 60 to 70 percent of patients are paid on a value-based system, practices will operate at a loss and ultimately return to FFS.

- **Consistency across payers.** Many current models contract with multiple payers, including Medicare and commercial payers, who have different contract requirements that often do not align. Quality measures and contracting and reporting requirements should be broadly consistent across payers to best encourage providers to pursue alternative models of care.
- **Constrained budgets for innovation.** In the current budget environment, the longevity of CMS's ability to continue to test models should be assured. With available resources, CMS needs to be able to accurately evaluate models of care and participants' performance in those models in order to scale and spread successful models nationally.

Next Steps

While BPC does not intend to address all of the challenges outlined above, over the coming months we will begin to explore solutions to some of the major challenges to developing and implementing alternative systems of care. Acknowledging that FFS will remain the basis for other payment mechanisms and will continue to exist in some areas, BPC will examine possible innovations in the existing FFS program, as well as bundling, PCMHs, additional improvements to ACOs, and other issues related to delivery system reform.

Endnotes

¹ Former Senate Majority Leaders Tom Daschle and Bill Frist, former Senate Budget Committee Chairman Pete Domenici, and former Congressional Budget Office Director Dr. Alice Rivlin.

² SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (S.2000/H.R. 4015), as introduced February 6, 2014, <https://beta.congress.gov/bill/113th-congress/senate-bill/2000?q=%7B%22search%22%3A%5B%22s.2000%22%5D%7D>.

³ As introduced in February 2014, S. 2000/H.R. 4015 was scored at \$138.4 billion over 2014-2024.

⁴ See: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf>; *Growth and Dispersion of Accountable Care Organizations: June 2014 Update*, Leavitt Partners Accountable Care Cooperative.

⁵ See: http://www.medpac.gov/documents/06162014_ACO_issue_letter_2014_COMMENT.pdf.

⁶ Qualifying APMs must involve risk of financial losses and a quality-measurement component.

⁷ In BPC's proposal, non-physician fee schedule providers are included in the differential.

⁸ For more information, see *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, Bipartisan Policy Center, April 2013.



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