

Produced by the Leonard Davis Institute of Health Economics and the Healthcare Transformation Institute at the University of Pennsylvania, with guidance from a national panel of experts.

THE FUTURE OF VALUE-BASED PAYMENT

Five Recommendations to Accelerate Adoption and Transformation

A decade of innovation and experimentation has failed to transform the health care system to one that pays for value rather than volume. It is now time to reconsider how value-based payment models can generate substantial savings and improve quality and health equity. Experts from the University of Pennsylvania, with input from a national panel of experts, reviewed the effectiveness of past payment reforms implemented by the Centers for Medicare and Medicaid Services (CMS) and made [recommendations](#) about how to accelerate and complete the nation's transformation to value-based payment. This brief summarizes recommendations that provide a path toward widespread adoption and success of alternative payment models, producing better health outcomes for all Americans, reducing wasteful spending, improving health equity, and more effectively stewarding taxpayer funds to support other national priorities.

RECOMMENDATIONS

1 CMS should articulate a clear vision and strategy for the evolution of value-based payment, implemented through a carefully managed portfolio of initiatives and aligned across payers, service lines, and health plans.

- To support this vision, CMS should take a portfolio-based approach that balances investments across payment models, with the specific allotments based on desired high-level goals, such as reducing per-beneficiary costs, improving value, and addressing health equity. Such a division of investments would guide how CMS allocates resources and measures success.
- To expand and fully establish alternative payment models across markets and beyond Medicare and Medicaid, the federal government should align payment policy across all public and private programs that receive federal funding. This includes Medicare, TRICARE, Veterans Health Administration, the Federal Employee Health Benefits Program, commercial plans sold on ACA exchanges, Medicaid, and managed care in both Medicare and Medicaid.

2 CMS should move away from voluntary programs toward mandatory participation in advanced payment models, whenever feasible.

- Mandatory participation simplifies and accelerates the adoption of new payment models and produces fair competition when benchmarks are set regionally. Mandatory programs also reduce the likelihood that providers will adapt to these models by avoiding caring for high-risk patients.
- Mandatory programs allow for more rigorous evaluation, which in turn produces robust results, allowing the best versions of models to emerge and diffuse more rapidly.

3 When requiring participation in advanced payment models is not feasible, CMS should encourage providers to participate by reducing the administrative burdens, committing to long-term contracts, and reducing the attractiveness of fee-for-service arrangements.

- Advanced payment models can be more attractive through administrative simplification and multi-year contractual commitments. For example, regional benchmarks can reduce participants' data burden and produce a more level playing field across providers. Longer contracts signal a commitment to program success from CMS, and encourage providers to make greater technical and programmatic investments in early years, with expected savings accruing in later years.
- CMS should re-evaluate the current physician fee schedule, which is biased towards procedures, overvalues several specialty procedure codes, and undervalues primary care. The goal should be to reprice the most used billing codes based on value, and to lessen the comparative advantage of remaining in fee-for-service arrangements rather than transitioning to advanced payment models.

4 For health systems already participating in value-based payment, CMS should accelerate the movement from upside-only shared savings to risk-bearing, population-based alternative payment models.

- The number and complexity of existing value-based models encourages providers to chase small pools of shared savings, rather than systematically transforming their practice. Slowing the introduction of new models, reducing the overlap between models, and aligning their financial design will encourage systems to take on significant risk and responsibility for a defined population.
- In balancing and rebalancing its portfolio of advanced payment models, CMS should invest more heavily in high-performing arrangements that involve both shared savings and losses.

5 CMS should proactively promote equity with advanced payment models that prioritize reducing disparities and tie health equity outcomes to financial outcomes.

- In most cases, advanced payment models should include explicit, direct funding that targets the care of populations with social risk factors—including funding for community health workers, community-based services, and teams that integrate health and social services. CMS should require participants to screen for social risk and track those data in electronic health records.
- CMS should improve its approach to measuring social risk, which may require intra-agency coordination to develop new standards for data collection and valid measures of health equity. All publicly reported patient outcomes, such as readmission rates, should be stratified by social risk factors.
- To further address health equity, CMS should implement policies that require Accountable Care Organizations (ACOs) and other risk-bearing groups to produce equity impact statements with measurable goals, clear metrics for success, and a commitment to make this information publicly available.

CURRENT EVIDENCE

Alternative payment models can reduce costs and improve quality, although the savings and quality gains have been modest thus far. The decade of experimentation has produced the necessary knowledge to design and implement alternative payment models to transform health care delivery. CMS should expand the most promising models and phase out underperforming ones.

- Bundled payment models have produced modest per-episode savings for surgical procedures, most notably lower extremity joint replacements. For medical conditions, bundled payments have yielded small or no savings.
- Population-based ACOs have generated modest per-beneficiary savings, with improvements along several quality dimensions. Physician-led ACOs have produced greater savings than hospital-led ACOs by reducing hospitalizations, and these savings increase the longer participants remain in the program.
- Programs that use two-sided risk (that is, shared savings and losses) have the greatest impact. However, providers have been reluctant to take on considerable risk in their practices, especially because of the continued profitability of continuing to be reimbursed through fee-for-service payment.
- There is no clear evidence of improvements in health equity.

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The Leonard Davis Institute of Health Economics at the University of Pennsylvania catalyzes and facilitates multidisciplinary research and educational programs, shaping and expanding the knowledge required to improve population health, the health care system, and health policy.

ABOUT HTI

The Healthcare Transformation Institute at the University of Pennsylvania is a new initiative aimed at increasing the value of the U.S. health care system through new innovations designed to improve quality, affordability, and the patient experience.