When it comes to the "Triple Aim" of healthcare, a lot of hopes are riding on value-based care service models and alternative payment models (APMs). In our most recent blog post, we touched on recent APM-related developments, including a landmark value-based end-stage renal disease (ESRD) payment model addressing health equity and the test of a new direct contracting model. We also took a glimpse at the different "levers for success" available in direct contracting.

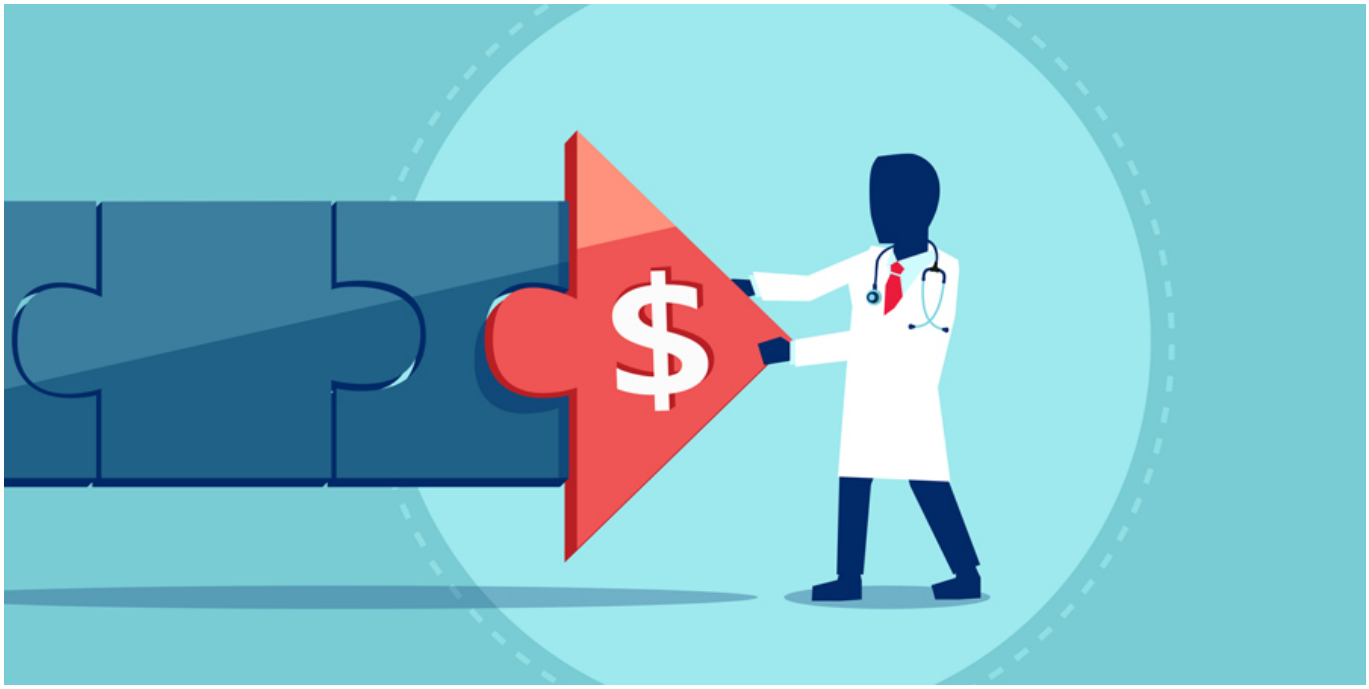
In these changing times, speculation, prognostication and preparation abound: What does it all mean, where is it leading, and what do we need to do to be ready?

Taking the next steps in the journey toward value

Since the start of this year, the Center for Medicare & Medicaid Innovation (CMMI) has undertaken a strategic review of all current APMs. Concerned about the number and complexity of models, it seeks to streamline the options while investing in those with the greatest potential impact. This would lower the administrative burden for model participants. CMMI's position is consistent with the recommendation by the Medicare Payment Advisory Commission (MedPAC) that CMMI reduce the number of APMs launched.

CMMI is shifting its focus from providers to patients, determined that each patient be in a "care relationship" whose goals are incorporated into CMS's and CMMI's assessment of quality. Increased participation in APMs is a top priority. CMMI Director Liz Fowler believes the shift away from traditional fee-for-service Medicare has "lost momentum," citing an insufficient penalty for remaining in such arrangements.

During a June 3 appearance on C-SPAN's Health Affairs Speaker Series, Fowler told *Health Affairs* editor in chief Alan Weil that she and CMMI would continue to pursue mandatory models, noting that the Obama and Trump administrations both made efforts in that direction. While recognizing that these models present their own challenges, she noted the selection bias inherent in voluntary models.



Read our latest: [Where we stand with APMs: The (value-based) beat goes on]

"Voluntary models are subject to risk selection, which has a negative impact on the ability to generate system-level savings," she said. "Providers that aren't generating the extra revenue tend to exit the program, and those that are tend to stay."

CMMI will pursue "meaningful accountability for total cost of care," Fowler said. But episodic models, which measure the quality of a patient's care across an entire health episode such as a single illness or course of treatment, "aren't going anywhere." Fowler is encouraged by the renewed focus on advanced primary care and the interest in direct contracting, but considers certain conditions and circumstances too challenging for a primary care provider (PCP) or even an ACO to manage. She finds it unlikely, for example, that CMMI would roll out an episodic model for diabetes because the PCP is better suited to manage that patient longitudinally, but episodic models would be more appropriate for high-cost, lower-volume conditions.

Fowler did not address the Geographic Direct Contracting Model, which had been scheduled to begin on January 1, 2022, but was placed "under review" by the Centers for

Medicare & Medicaid Services (CMS), or the new type of direct contracting entity (DCE) introduced in December 2020 for Medicaid managed care organizations (MCOs). She did express her belief that direct contracting in general can be effective, while acknowledging that it is more attractive to the "disruptors and innovators" than accessible to a wide range of organizations.

Predictions for episodic care and APMs

The pausing of the Geographic Direct Contracting Model is not unusual, said Valinda Rutledge, executive vice president of federal affairs at America's Physician Groups (APG), during an appearance on naviHealth's *SOAP Notes With Dr. Jay LaBine* podcast.

Valinda Rutledge
Executive VP, Federal Affairs
America's Physician Groups

"It's not uncommon when a new administration comes in to pull back and say, 'Are these models aligning with our priorities?'" Rutledge said. Pushback against the models has come from two camps, she said: 1) current ACOs "concerned that a Geographic entity would overtake them in terms of beneficiary assignment," and 2) beneficiaries concerned about the effect of nontraditional providers and the privatization of Medicare fee-for-service arrangements. CMMI is addressing those issues, she said.

Like Fowler, Rutledge sees mandatory bundled payments for episodic care on the horizon but pointed out the problem of selection bias. "As we continue to look at population-based models and primary care models, bundles become the vehicle in which we can engage the

specialists," she said. The question then is whether to develop bundles tied to specific conditions, and if so, which ones.

"Not all providers are ready to take substantial risks or start moving into capitated payments," Rutledge said. Bundled payment arrangements — which include financial and performance accountability for episodes of care in a bid to increase quality and care coordination at a lower cost to Medicare — offer "a pathway to help smaller and less sophisticated providers begin that journey."

She added, "The broader question is: How do we take bundled episodic payments and embed them within a population base? Can you take it and embed it within direct contracting? Global contracting?"

Dr. Patrick Conway
CEO, Care Solutions
Optum

Dr. Patrick Conway, CEO of Care Solutions at Optum, part of UnitedHealth Group, expressed similar thoughts during his own appearance on *SOAP Notes*.

"I think you need population-based models to care for whole populations of people. I also think you need episodic models that are (addressing) total cost of care, quality and experience. … There are going to be places (where) you're going to embed an episode model in a population-based model," Conway said.

Conway also expects to see mandatory bundles in the Biden administration, along with "a push for more population-based payment models." He added: "I'm bullish on what we're

going to see … on pushing toward value. The private sector is pushing in that direction as well, so the combination efforts just mean that if you're a hospital or a physician group in America, you know where the world is going, so how do you perform in this value-based world?"

Both Rutledge and Conway see the entire industry starting to move away from the fee-for-service mindset. As CMS has emphasized, fee-for-service "can result in fragmented care with minimal coordination across providers and healthcare settings," and CMMI has recommended moving away from it.

"In these population models there was a lot of concern about quality or experience going down," Conway said. "Actually, in general, across the public and private care models, quality and experience have increased even faster than costs have gone down. So I think as you put in a coordinated care system, quality and experience get better.

"In the fee-for-service system, the fragmentation is really painful for people. You're an adult or child with 12 chronic conditions and no quarterback. You're a caregiver … trying to coordinate across multiple physicians and teams. So the more we can do to have a coordinated health system that centers on the individual and family, the better. And I think value-based care helps us do that."

To learn about "Direct Contracting Participation: Navigating Capitation, Quality and the Future Landscape," check out our on-demand webinar.

Watch the webinar