CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

5 Fatal Flaws in Total Cost of Care & Population-Based Payment Models

What is Needed to Make Value-Based Payment Successful?

The failure of current value-based payment programs to significantly reduce healthcare spending has resulted in proposals to (1) require providers to take "downside risk" for all of the services their patients receive, and (2) completely replace fee-for-service payments with "population-based payments."

There is no evidence that requiring providers to take financial risk for the total cost of care or replacing fees with capitation will be more successful than shared savings models in controlling spending while maintaining quality. In fact, there is good reason to believe these types of programs would cause more problems than they solve because of five fundamental flaws in the ways such programs operate:

1. The budgets and spending targets that are used will always be wrong;
2. Providers don't receive adequate funding for care of higher-need patients;
3. The quality measures that are used don't protect patients against undertreatment;
4. Providers have no greater ability to deliver high-value services than under standard fee-for-service payments; and
5. Patients don't have a choice about whether to participate.

The Fatal Flaws in Total Cost of Care and Population-Based Payment Models

1. Budgets and Spending Targets Will Always Be Wrong

An essential component of total cost of care and population-based payment models is a *budget, target, or "benchmark"* for the total amount that can be spent on all of the healthcare services a group of patients receives. If a physician group, health system, or Accountable Care Organization (ACO) participates in the payment model, it is penalized if the actual spending on its patients is above that budget/target, and it is rewarded if the spending is lower. (In a population-based payment or capitation system, physicians, hospitals, and other providers are expected to deliver all of the services their patients need in return for a fixed payment per patient; the budget for a group of patients is simply the amount paid per patient times the number of patients.)

Three different methods have been used to establish these budgets and spending targets, each of which has serious flaws:

- **Method 1: Trend from the Past.** One method sets the budget/target based on a forecast of the increase in spending that will be needed compared to the past. However, as Yogi Berra once said, "it's tough to make predictions, especially about the future." Every year, new drugs and treatments are developed and new evidence emerges about which treatments are most effective; in addition, new diseases like COVID-19 can appear, and unexpected supply or workforce shortages can cause significant increases in costs. These inherently unpredictable events will inevitably cause the cost of high-value care to differ from the forecast, potentially by a large amount. CMS has had difficulty forecasting total spending for millions of Medicare beneficiaries (e.g., Part B premiums for 2022 were set based on what is now believed to be a significant overestimate of Medicare spending on the drug Aduhelm), so budgets based on projections for smaller groups of patients are even less likely to be accurate.
- **Method 2: Comparison to Other Providers.** A second method sets the budget/target at a level below what is spent by providers who are *not* participating in the risk-based payment model. This method implicitly assumes the non-participating providers are delivering unnecessary or avoidable services and that the providers who are at risk for spending can save money by not delivering similar services. However, if the comparison group of providers has healthier patients or is undertreating their patients, a budget based on their spending will be inadequate. Moreover, it will be difficult to find an appropriate comparison group if most or all providers are participating in the risk-based payment model. (The so-called "rural glitch" in the Medicare Shared Savings Program is caused by trying to compare spending for patients in an ACO to spending on other patients in the community when most of the patients are in the ACO.)
- **Method 3: Percentage of Insurance Premiums.** The third method sets the budget or target spending for the patients at a percentage of the total insurance premiums their health plan receives for them. Although low premiums help a health plan attract more members, normally the premiums have to be high enough to pay for the healthcare services those members need. However, under a percentage-of-premium arrangement, the health plan no longer has to worry about spending more than the premium revenues it receives. If premiums are too low to cover the costs of the services the plan members need, the providers are penalized, not the health plan.

None of these approaches bases the budget or target on an estimate of how much it would actually *cost* to deliver appropriate, high-quality care to patients. The Medicare program has always set the fees it pays for individual services based on a detailed analysis of the cost of delivering those services. However, no similar process has

been established to determine the right amount of total spending that is needed to deliver all of the services a group of patients will need.

Moreover, the budgets and spending targets in all three methods are increasingly being driven by arbitrary decisions about how much spending is *desirable*, regardless of whether that is actually *feasible* for physicians or hospitals to achieve. If a payer wants to spend less money, it can simply increase the annual budget/target by a smaller amount, regardless of the actual increase in the costs of labor or supplies the providers experience, or it can require a larger "discount" without any analysis showing how the reduction in spending could actually be achieved.

2. Providers Don't Receive Adequate Funding for Higher-Need Patients

Patients with greater health needs require more healthcare services, so spending on these patients will inherently be higher than on other patients. In addition, patients with complex conditions and those who face social barriers to improving their health will require more time and support from healthcare providers, and that will increase the cost of delivering services to them.

Although it is universally agreed that budgets and targets need to be "risk adjusted" in order to address differences in patient needs, current risk adjustment methods fail to do so effectively. For example, under the Hierarchical Condition Category (HCC) system used in most Medicare alternative payment models, a patient's risk score stays the same even if:

- the patient experiences one or more acute illnesses during the year, no matter how much it costs to treat those illnesses;
- the patient is newly diagnosed with a chronic condition, even though the patient will need treatment and assistance in managing that condition (the patient will not receive a higher risk score for the chronic condition until the year *after* they are diagnosed);
- the patient has a more advanced or complex version of a chronic condition that requires more services or more expensive treatments (the diagnosis codes for many conditions indicate the *presence* of the condition, but not its *severity*);
- the patient faces barriers to receiving healthcare services or improving their health, such as poverty, homelessness, illiteracy, lack of access to transportation and fresh food, etc.

Providers can be financially penalized under risk-based and population-based payment models if their patients have many acute illnesses, new chronic conditions, or barriers to health. The quality measures in these payment models do nothing to prevent patients from being undertreated.

If the risk scores don't increase when patients have greater needs, the budget for their care won't increase. As a result, the providers responsible for the budget will be financially penalized if a higher proportion of their patients have many acute illnesses, new chronic conditions, or barriers to health. In addition, Medicare places limits on how much the risk scores for a group of patients can increase over time. Although this is intended to discourage providers from recording additional diagnosis codes solely to increase the spending budget, it penalizes providers whose patients develop many new health problems.

3. Quality Measures Don't Protect Patients Against Undertreatment

A premise of risk-based and population-based payments is that physicians will stop ordering and delivering unnecessary services if they face penalties for exceeding a spending budget/target. Eliminating unnecessary services is desirable because it reduces spending without harming patients.

However, the budgets and targets make no distinction between spending on *necessary* versus *unnecessary* services. If the budget is set too low, the only option for avoiding a penalty may be to avoid delivering services that patients need or to use treatments that are cheaper but less effective. In this case, the lower spending does harm patients.

Moreover, in a population-based payment system, a provider is still paid the same amount for a patient even if the patient receives no services at all. If this causes the provider to reduce the number of patients they see or treat, it may be more difficult for patients to access the care they need in a timely fashion.

Contrary to popular belief, the quality measures used in risk-based payment programs do nothing to prevent patients from being undertreated. For example, in the Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs) are at risk for total spending on their patients, but:

- there are no measures of whether patients with cancer, rheumatoid arthritis, stroke, or other expensive-to-treat conditions are receiving appropriate care. If ACO patients with these kinds of conditions are given cheaper but less effective treatments, the ACO will be more likely to meet its spending target and there will be no negative impact on its quality scores.
- there is no actual penalty if the ACO performs poorly on any of the quality measures that are used in the program. At most, the ACO would receive a smaller shared savings bonus if it had reduced spending sufficiently to qualify for such a payment. On the other hand, the ACO will be penalized if spending exceeds the target, even if the higher spending was needed to deliver high-quality care.

In population-based payment systems, the payments may be reduced if the providers perform poorly on quality measures. However, quality measures don't assure that *each individual patient* will receive high-quality care; the ACO or provider group simply has to have better quality scores on average than other physicians or ACOs.

4. Providers Have No Greater Ability to Deliver High-Value Services

Fee-for-service payment is typically criticized because it "rewards volume instead of value." However, a bigger problem for patients and providers is the lack of payment or inadequate payment for many high-value services. For example, there are typically no fees for education and proactive care management services provided by nurses, community health workers, and pharmacists, for palliative care services, or for non-medical services such as transportation. In addition, the fees paid for office visits are often too low to allow physicians to spend adequate time with patients who have complex needs. All of this can cause patients to be misdiagnosed or experience poor outcomes that will result in higher spending on their care.

Most risk-based payment models don't solve these problems because they don't make any changes in what services are paid for or the amounts paid for those services. Although providers can receive a shared savings bonus if they deliver additional or different services that significantly reduce total spending, that bonus won't come until long after the services are delivered. Physician practices and other small providers cannot afford to incur additional costs to deliver more services with no assurance as to whether they will receive enough additional revenue to cover those costs.

In theory, an ACO that receives a population-based payment on behalf of its providers (rather than the providers receiving fees for services and shared savings payments) could pay the providers more or differently for their services. However, most ACOs do not have systems for paying physicians and hospitals for services unless they employ the physicians or own the hospitals. Forcing ACOs to establish claims payment systems would not only be expensive but wasteful, since it would duplicate the systems health plans already have in place.

The biggest improvements in care delivery have resulted from the small number of value-based payment programs that explicitly pay more to support the delivery of new services, such as Medicare's Comprehensive Primary Care Plus program, Oncology Care Model, and ACO Investment Model. Unfortunately, all of these programs have been terminated in favor of more problematic risk-based models.

5. Patients Don't Have a Choice About Whether to Participate

Most people would likely prefer not to be part of a system in which physicians can (1) be penalized for ordering or delivering treatments their patients need simply because the treatments are expensive, (2) receive a financial bonus for using less-effective treatments because they cost less, or (3) be paid even if they do doing nothing at all to help their patients, particularly if (4) patients in that system are unlikely to receive any more or better services than they would have otherwise. For decades, people have had the opportunity to enroll in HMOs that pay doctors using capitation, but most have chosen not to, and the majority of Medicare beneficiaries continue to enroll in Original Medicare despite the availability of "zero-premium" Medicare Advantage plans.

IDEAL	PROBLEMATIC PAYMENT MODELS			
PATIENT-CENTERED PAYMENT	**CATEGORY 1** FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	**CATEGORY 2** FEE FOR SERVICE – LINK TO QUALITY & VALUE	**CATEGORY 3** APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	**CATEGORY 4** POPULATION-BASED PAYMENT
• A patient is able to receive the services that will best address their specific health problems • Each patient is assured of receiving appropriate, evidence-based care • A healthcare provider receives adequate resources to support the cost of delivering services in a high-quality, efficient way • A patient can select a provider or team based on the quality and cost of the care they deliver	• There are no fees for many important services • Many fees are less than the cost of delivering high-quality care • There is no assurance of the appropriateness or quality of the service that is delivered • Healthcare providers are penalized for reducing complications and keeping patients healthy • It is impossible for a patient or payer to compare providers based on the cost of treating a health problem	• There are no changes in payments to enable improvements in the quality of care • Quality measures do not accurately or completely assess the quality of care delivered • Healthcare providers can be penalized for things they cannot control • There is no assurance that each patient will receive high-quality care • The calculation of bonus payments discourages collaboration in care improvement	• There are no changes in payments to enable improvements in the quality of care • There is no assurance that each patient will receive high-quality care • Providers are rewarded for withholding services patients need • Providers can be penalized if they care for higher-need patients • Small providers can be forced out of business • Money is spent avoiding losses instead of delivering patient care	• There is no assurance that patients will receive care when they need it • Payments may not be sufficient to cover the cost of delivering high-quality care • Providers are rewarded for withholding services patients need • Providers can be penalized if they care for higher-need patients • Small providers can be forced out of business • Investors, vendors, and financial intermediaries can profit at the expense of patient care

However, under the risk-based payment systems used by Medicare and many commercial health plans, patients don't have a choice. For example, in the Medicare Shared Savings Program, a patient is automatically "attributed" or "assigned" to an ACO if the patient receives most of their primary care services from physicians who are part of the ACO, regardless of whether the patient wants to be assigned or not. If a patient is concerned that they could receive less effective treatments because the ACO is required to reduce spending, the only way they can escape assignment is to find a primary care physician who is not part of an ACO or to not seek primary care services at all. This could also cause patients to receive less effective care.

There is no evidence that total cost of care and population-based payment models will be more successful in controlling spending than other value-based payments, but they are likely to reduce patients' access to prevention and treatment, increase health inequities, and cause more provider consolidation. In contrast, Patient-Centered Payment can solve the problems with fee-for-service payment without these negative impacts.

These attribution systems are also problematic for the physicians who are participating in the risk-based payment program, since a single visit with a patient could cause the physician to be held responsible for all of the services the patient received during the entire year, including services delivered before the physician ever met the patient.

The Negative Impacts of Downside Risk and Population-Based Payment

Although proponents claim that downside risk and population-based payments are desirable because they can support "population health" and "coordinated care," the negative impacts of the flaws described above can easily outweigh any benefits:

- **Reduced Access to Prevention and Treatment.** Most health insurance companies control their spending by finding ways to deny or delay services, so if they shift risk to providers along with insufficient funding, the providers will be forced to do the same thing. Patients could be placed on waiting lists for services, just as they are in other countries that arbitrarily cap healthcare spending. Preventive services could suffer the most, since they increase costs in the short run but may not produce savings until many years in the future.
- **Greater Health Inequities.** The patients who are most likely to be harmed are those with the kinds of complex needs and social barriers to health that current risk adjustment systems ignore. These patients already experience worse outcomes, and disparities will increase when payments are not adequate to cover the costs of the services they need.
- **More Provider Consolidation.** Risk-based payments are biased in favor of large health systems and physician groups. For example, in the Medicare Shared Savings Program, ACOs are required to have at least 5,000 assigned beneficiaries in order to participate, and the most favorable financial rules apply to those with 60,000 or more beneficiaries. Requiring providers to take significant downside risk will force small physician practices and hospitals to close or to consolidate with larger systems, which usually leads to higher costs and lower quality care.

The full extent of these impacts has not yet been seen because most payment models to date have not included significant downside risk. However, the negative impacts could be significant if more physicians and other healthcare providers are forced into risk-based payment models and the levels of risk are increased. Many of the resulting harms will likely be irreversible.

A Better Way: Patient-Centered Payment

Fortunately, there is a better way to implement value-based payment and support accountable care than simply shifting risk to providers. A *Patient-Centered Payment* system can solve the problems in current fee-for-service payment systems without reducing access to services or the quality of care for patients. In a Patient-Centered Payment system:

- **A patient is able to receive the services that will best address their specific health problems.** The current gaps in fee-for-service payments should be explicitly filled, and savings should be achieved by reducing unnecessary and avoidable services, not by forcing physicians to use cheaper, less effective treatments.
- **Each patient is assured of receiving appropriate, evidence-based care.** Healthcare providers should provide high-quality care for *each individual patient*, not just provide care that is better *on average* than other providers.
- **A healthcare provider receives adequate resources to support the cost of delivering necessary services in a high-quality, efficient manner.** Payments should be based on what it actually *costs* to deliver good care, not simply what payers would like to spend.
- **A patient can select physicians based on the quality and cost of the care they deliver.** No one provider or health system will be the best at delivering all of the services an individual patient may need, so patients should not be forced to receive care only from a "narrow network" chosen by a health plan or health system.

Patient-Centered Payment systems with these characteristics have already been developed for primary care, chronic disease care, cancer care, maternity care, and other conditions. They simply need to be implemented by Medicare and other payers. The details on how to do this are available at PatientCenteredPayment.org.