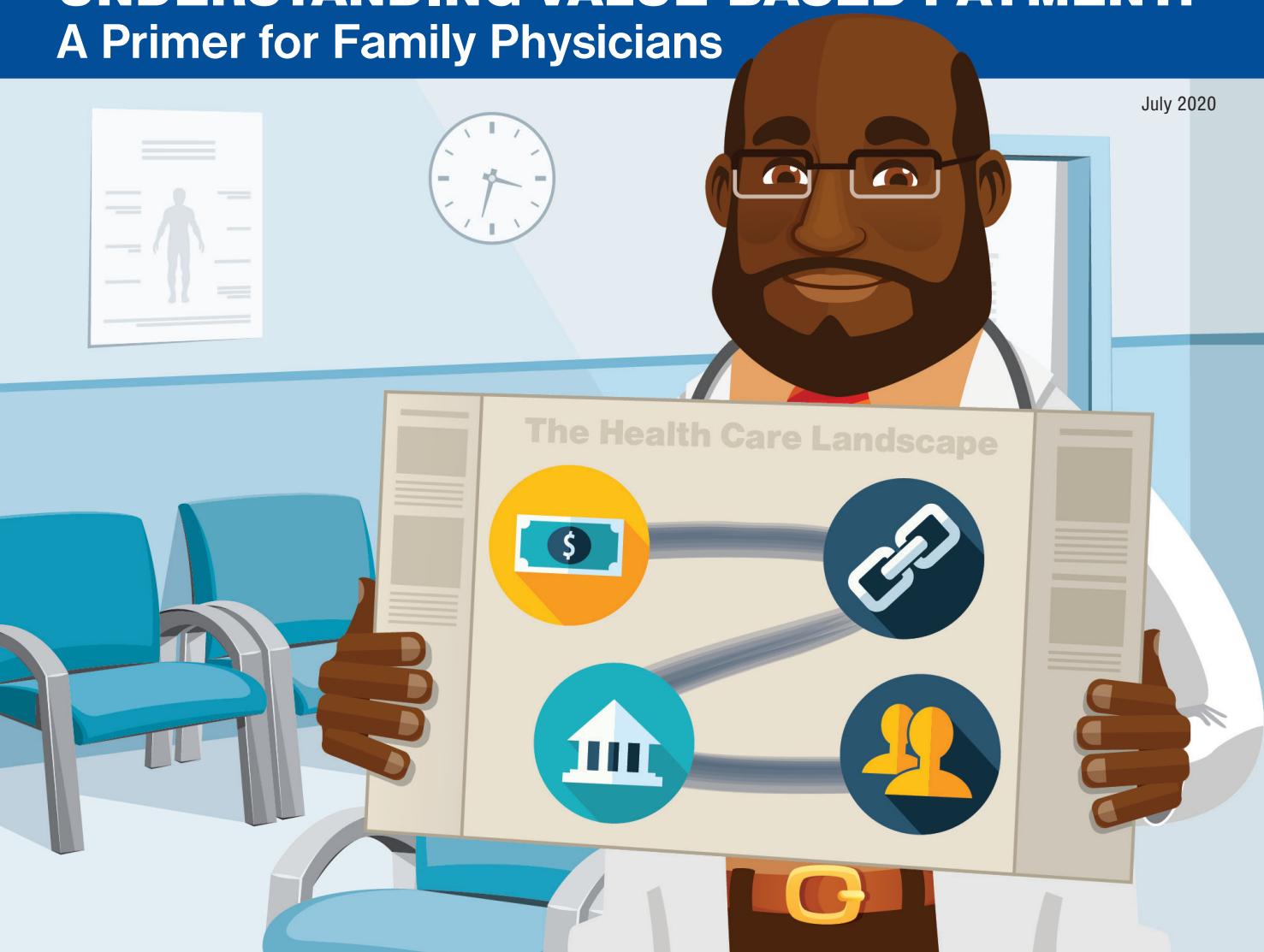


# UNDERSTANDING VALUE-BASED PAYMENT:

## A Primer for Family Physicians

July 2020



The health care landscape evolves at a rapid pace. One trend among payers that impacts family physicians and other health care providers is value-based payment. Public and private payers are transitioning away from fee-for-service (FFS) and emphasizing value-based payment models.

## Delivering High-quality, Value-based Care

This is a critical time in health care for family physicians to emphasize that primary care is value-based care through comprehensive, longitudinal, high-quality care that reduces cost and improves outcomes. For solo, independent physicians, changes in revenue from these new models will have a direct impact on your practice's bottom line. For employed physicians, employers will begin to place a greater emphasis on performance on quality and utilization of care in determining compensation.

## Value-based Payment Concepts

The overarching goals of transitioning from volume to value-based payment models are shared financial risk and holding physicians and other health care providers accountable for the quality and cost of health care. The key concepts of value-based payment (i.e., shared risk, population-based payments, bundled payments) align with providing value to patients through incentivizing outcomes. However, these payments alone are not sufficient to achieve a value-based care system.

HCP-LAN APM Category	Payment Components
 <b>Category 1</b> Fee-for-service (FFS) with no link to quality or value	Standard payment issued for individual services provided. Incentivizes volume over value.
 <b>Category 2</b> FFS with link to quality and/or value	Most payment is still based on volume. However, additional adjustments are based on quality performance.
 <b>Category 3</b> Alternative payment models (APMs) built on FFS	Claims are still submitted for FFS payments. However, additional incentives are paid for quality and cost performance for attributed patients. Participants assume varying levels of upside and/or downside financial risk. A small per member per month care management fee may also be provided.
 <b>Category 4</b> Population-based payments	Payment is mainly provided through a prospective population-based payment for attributed patients. Partial capitation is a fixed dollar amount for a specific set of services (e.g., office visits). Services not included in the capitation amount continue to be paid under FFS. Full capitation is a fixed dollar amount for all services. Additional incentives are typically provided for quality and/or cost performance.

Adapted with permission from the Health Care Payment Learning & Action Network's Alternative

Value-based care and its corresponding payment models should:

- Support the delivery of longitudinal, comprehensive care (i.e., value-based care)
- Support the flexibility in value-based care management to meet patient needs
- Support health equity and reduce disparities in care
- Support a strong patient-physician relationship
- Align across payers and programs
- Balance increased administrative complexity with the incentives of the program

### Types of Value-based Payment Arrangements

The Health Care Payment Learning & Action Network (HCP-LAN) ([hcp-lan.org](http://hcp-lan.org)) created the following alternative payment model (APM) framework ([hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf](http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf)) to help guide the alignment of payment reform across payers and physicians and health care providers. As the shift from volume to value continues, ideally, an increasing amount of payment contracts will shift further down the risk spectrum toward population-based payments, which better support value-based care.

How Payment Supports Value-based Care	Payer Examples
FFS does not inherently support the transition to value-based care, as it is driven by volume and limits physicians' abilities to provide innovative care.	Traditional Medicare and standard private payer contracts with no payments linked to quality and/or value
Adjustments based on quality may allow practices to begin transforming to value-based care by providing additional—albeit often minimal—payment tied to quality.	<ul style="list-style-type: none"><li>• Private payers paying small incentive for meeting medical home standards or Healthcare Effectiveness Data and Information Set (HEDIS) measures (e.g., Michigan's Meridian HEDIS Bonus Program)</li><li>• Merit-based Incentive Payment System (MIPS) (<a href="http://aafp.org/macra">aafp.org/macra</a>)</li><li>• Pay-for-reporting</li></ul>
The additional payments for taking on accountability for cost in this category encourage physicians to better understand the individual needs of their patient population by providing the right care at the right time in the right place. While not insignificant, the prospective payments in this category do not replace the FFS mechanism, so physicians are still significantly tied to volume.	<ul style="list-style-type: none"><li>• Comprehensive Primary Care Plus Track 1 (<a href="http://aafp.org/cpcplus">aafp.org/cpcplus</a>)</li><li>• Medicare Shared Savings Program (MSSP) (<a href="http://aafp.org/aco">aafp.org/aco</a>)</li><li>• Accountable care organizations (ACOs) (<a href="http://aafp.org/aco">aafp.org/aco</a>)</li></ul>
Prospective capitated payments not specifically tied to in-person visits allow the most flexibility in care delivery for family physicians. This payment mechanism can be used to cover a wide range of innovative delivery system components that encompass preventive care, care coordination and management, and wellness services in the most appropriate setting for the patient and physician.	<p>Partial Capitation:</p> <ul style="list-style-type: none"><li>• Comprehensive Primary Care Plus Track 2 (<a href="http://aafp.org/cpcplus">aafp.org/cpcplus</a>)</li><li>• Primary Care First (<a href="http://aafp.org/pci">aafp.org/pci</a>)</li><li>• Direct Contracting Professional Option (<a href="http://aafp.org/pci">aafp.org/pci</a>)</li></ul> <p>Full Capitation:</p> <ul style="list-style-type: none"><li>• Direct Contracting Global Option (<a href="http://aafp.org/pci">aafp.org/pci</a>)</li></ul>

## Risk Arrangements in Value-based Payment

Upside risk provides financial incentives based on performance. In upside-only arrangements, physicians do not assume any downside risk. Downside risk adds an element of financial risk when quality and cost performance is below target.

Shared savings and shared loss arrangements compare a physician's actual costs to a benchmark. If a physician's costs are below the benchmark, the payer returns a portion of the savings to the physician. If a physician's costs are above the benchmark, the physician must pay a portion of the losses back to the payer. The percentage of savings/losses a physician may receive varies by arrangement and often considers the physician's quality performance.

## Impacts for the Future of Family Medicine

In 2019, the HCP-LAN set forth aggressive new goals to accelerate health care payments tied to quality and cost across all payment sectors, including a goal of 100% of Medicare and Medicare Advantage payments linked to value by 2025.

### HCP-LAN's APM Payment Goals Tied to Quality and Value

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

Used with permission from the Health Care Payment Learning & Action Network (<http://hcp-lan.org>).

For family physicians, these goals mean fostering new skill sets and focusing on outcomes that matter to patients. The American Academy of Family Physicians (AAFP) is here to help prepare you for this transition and is dedicated to providing education, tools, and resources to help our members succeed in the value-based payment world.

This content is part of a series of supplements developed by the AAFP to help you gain a better understanding of value-based payment and how it may impact you and your practice. The series outlines skills necessary to be successful in these arrangements, including:

- Accurately identifying patients' associated risk level
- Providing appropriate care management and coordination services to patients with high cost and/or high needs
- Appropriately documenting disease severity to better capture the risk of your patient panel
- Becoming familiar with available data and how to make it actionable at the point of care