The health care industry is on a path toward value-based payment and away from the costly fee-for-service model that drives up volume. Private payers are increasingly collaborating with providers to develop payment models that reward high-quality outcomes and achieve savings.

This issue brief examines how community health plans are implementing value-based alternative payment models and highlights specific and replicable strategies from Alliance of Community Health Plan (ACHP) members.

ACHP member plans have extensive experience in paying for value and offer best practices, whether a health plan is integrated with a delivery system or contracts with outside providers. Visit our website for detailed case studies of successful payment models in place at ACHP member plans.

Successful implementation of alternative payment models requires four critical strategies, discussed in detail here.

**STRATEGY ONE:**
Introduce increasing levels of risk gradually, regularly assessing for provider and practice readiness and investing in care management capabilities.

In the fee-for-service model, insurers bear the financial risk. Providers have an incentive to deliver a high volume of care, and the government or health plans pay the price. In value-based payment models providers share in the responsibility of delivering high-value health care, often taking on some financial risk. For practices to succeed, this transition to shared risk between payer and provider must be undertaken incrementally, with significant investment in care management capabilities.

*Tufts Health Plan* in Watertown, Massachusetts, for example, introduces risk gradually along a spectrum and individually evaluates provider groups at each step to assess their readiness to assume more risk.

**STRATEGY TWO:**
Tailor measures to the performance improvement goals of physician practices.

Understanding what constitutes quality and how it is rewarded requires a set of performance measures that reflects desired outcomes. However, the volume and type of quality measures used vary from market to market. Although the Centers for Medicare and Medicaid Services (CMS) is actively working to identify a standard measure set, there is not yet a uniform approach to quality measurement, particularly in alternative payment models.

*UPMC Health Plan* in Pittsburgh, Pennsylvania, collaborates with clinicians to develop measures reflecting the needs of payers, providers and patients in order to drive value-based payment models.

ACHP member plan successes include:

- In 2014, *CDPHP* realized a $17.11 per-member per-month reduction in the total cost of care, resulting in an overall cost reduction of 2.9 percent, or $20.7 million. These savings were accomplished while increasing payments to primary care providers by $10 million.

- *Independent Health* implemented a payment model with a large urology group in which the group took full risk for all drug spending, utilization of unnecessary testosterone drugs has dropped 17 percent for commercial members and more than 15 percent for Medicare Advantage beneficiaries. The provider group is projected to earn roughly $1 million in shared savings this year, and the plan will reduce costs after spending $8 million per year on testosterone drugs prior to the program.

- *Tufts Health Plan* has 86 percent of its Massachusetts Commercial HMO network participating in a value-based alternative payment model, and 29 percent of its network participating in full-risk capitation in which providers adopt 100 percent risk for a negotiated per-member-per-month budget amount.
STRATEGY THREE: Develop actionable performance data, to include patient satisfaction and clinical outcomes measures, and initiate frequent payer-provider engagement to drive improvement and share best practices.

Data are valuable only if actionable. Performance data — which include quality, cost and patient experience and health outcomes — should highlight clear improvement targets and a path for achieving them. Health plans are essential in this process. Many ACHP plans hold regular meetings with physician practices to jointly review data reports, identify opportunities for improvement — often at the individual physician level — and share best practices.

HealthPartners in Minneapolis, Minnesota, focuses on helping provider groups envision success and leaders from the plan meet with all members of the clinical team regularly as the practice transforms to value-based care. The plan also develops quarterly reporting in a format customized to each practice.

STRATEGY FOUR: Provide cost and quality information at the individual clinician level and when possible, ensure that payment incentives go to both practices and individuals.

It is important to strive for a system in which individual clinicians are rewarded beyond what is given to their practice. If they are not, it is possible that while a large physician group or hospital may be paid under an alternative payment model, the individual providers will still be reimbursed on a fee-for-service basis. Targeting payment to individual clinicians rewards the highest performers and creates a culture in which all players on the clinical team strive for higher-quality care.

Security Health Plan in Marshfield, Wisconsin, uses quality performance, based on CMS star ratings, to determine the percentage of total savings received by providers, at the individual physician level.

Conclusion

The growing adoption of value-based alternative payment models is a key ingredient in transformation of the health sector. This transformation can draw on the experience of successful health plans and providers, such as those reported in this brief, to inform payment and policy decisions. For these models to be successful, ACHP has identified four core requirements.

Payment reform that truly changes the trajectory of health care costs in the U.S. depends on broad national policy that can be tailored to the unique needs and structures of local communities. We hope that the recommendations and examples provided in this brief can serve as important catalysts for change at both levels in the coming years.

Moving to value-based payment

» Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 to reform physician payment.

» The Centers for Medicare and Medicaid Services is transitioning to value-based alternative payment models, using the Health Care Payment Learning and Action Network to identify best practices and effective strategies.

» Physicians moving away from fee-for-service payment will be rewarded either through a Merit-Based Incentive Payment System or participation in alternative payment models.

» New regulations will guide the reformed physician payment system starting in 2019.

In Moving Beyond Fee-for-Service (2013), ACHP recommends physician payment reform begin in primary care, with specific attention to the infrastructure needed to coordinate care and share accountability for health outcomes and total cost across a diverse patient population. As primary care practices evolve, specialty care payment reforms can be developed. This issue brief builds on those recommendations.

Additional information on plan approaches to alternative payment, as well as case studies and results are available on ACHP’s website at achp.org.