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PEOPLE FIRST CARE

Working Toward True Health Care Payment Reform to Ensure Our Health Care System Serves Families and Patients

December 2022

All families and people across our nation should have access to the health care they need at a price they can afford. But our health care system, rather than being designed to produce the highest-quality care for the lowest possible cost, is currently designed to rake in the highest possible profits for big health care corporations.

The health care sector has lost its way

Some of the most talented people in our nation work in the health care sector, and some of the most important health care innovations across the globe are made here in the United States. Despite this, our families have worse health outcomes than families in other developed countries, and health care is becoming less and less affordable for many Americans.[1,2,3] For example, the U.S. has the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[4] Furthermore, health care-associated infections are one of the top 10 causes of death in the U.S., causing more than 72,000 patients to die each year.[5] These health outcomes are even worse for people of color, who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[6]

To make matters worse, nearly half of all Americans have had to forgo needed medical care due to cost while CEOs of medical monopolies and large health care corporations have raked in billions of dollars in profits.[7,8] The rising cost of health care is crippling U.S. families financially. More than 100 million Americans have been forced into medical debt, and 63% of them have had to cut spending on food, clothing and other basic necessities because of this debt.[9] Health care spending now accounts for nearly 20% of the U.S. gross domestic product, and total U.S. health care spending nearly doubled in just a decade, rising from $2.6 trillion in 2010 to $4.1 trillion in 2020.[10] During that same period of time, average family health insurance premiums increased by almost 50%. As a result, premiums have grown 50% faster than our paychecks and 2.5 times faster than overall inflation.[11] This rising cost of health care also translates into higher copays and deductibles, and all of these costs put a significant strain on our economic security.

This national scandal is driven by how the U.S. pays for health care. For too long, the U.S. health care system has enabled the business model of these large health care corporations to thrive by buying up community doctor's offices to form medical monopolies and set prices, and to generate high volumes of high-priced services with no accountability on affordability, health outcomes or the economic security of our nation's families.[12,13] Fee-for-service payment incentivizes health care providers to make money by performing more high-profit or high-margin procedures, rather than by allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.[14] It is critical to note that FFS provider payments predominate in all forms of insurance, including private employer-sponsored coverage, managed care, Medicare and Medicaid, and all forms of insurance have the potential to reorient incentives to move away from FFS provider payments.[15]

The U.S. fee-for-service health care system incentivizes surgeries, hospital admissions and medical tests, without any real link to the quality of care. Fees for hospital admissions, procedures, office visits and tests are priced too high, and

The U.S. Health Care System's Distorted Payment Structure

LARGE HEALTH CARE CORPORATIONS:

BUY up community doctor's offices, forming medical monopolies to set high prices.

INSTITUTE fee-for-service provider payment structure to generate maximum profits.

CAUSE families to have poor health outcomes, financial insecurity and worsened health disparities.

fees for making care accessible and effective often are priced too low or at zero.[16] Patients can be billed for each additional service, driving up the cost of their care.[17] A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.[18]

Even more problematic is the fact that FFS economics fail to adequately address factors that actually determine health. It is well established that 80% to 90% of what drives variations in peoples' health is determined by the socioeconomic and environmental factors in their lives, yet the predominant model for how health care is paid for in the U.S., including the majority of value-based payment models, offers no payment for addressing the social determinants of health.[19] By definition, FFS provider payments (in Medicare Advantage, Medicaid managed care, private health insurance, or traditional Medicare and Medicaid) provide a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives 10% to 20% of health.[20] By offering no payment for services that address the social determinants of health and paying so much for hospital admissions and procedures, the economic incentives of FFS actually work against the professional responsibilities and desires of providers to improve health or reduce disparities.

To solve this national crisis, we must have an honest discussion about the underlying financial incentives that are driving the health care sector, and we have to change these incentives to ensure that the health care sector makes money only when it is focused on keeping people healthy or efficiently providing the most effective treatments in a well-coordinated way when patients are sick. And, importantly, such payment reforms must ensure that health care is affordable and that families are economically stable in seeking and receiving health care services.

There has long been broad, bipartisan recognition that we need to reform health care payment.[21] But the health care industry so often is double-dealing when it comes to payment reform. While big health care corporations have been price gouging and paying their CEOs tens of millions of dollars, many of these same medical monopolies and other actors in the

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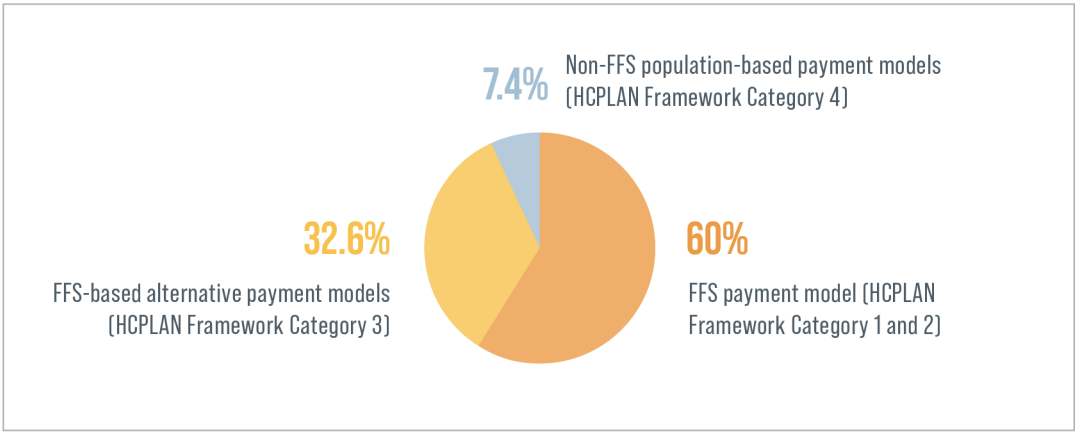
health care sector have been aggressively marketing to the public and policymakers about their movement away from FFS and toward new value-based payment models.[22,23] Meanwhile, payment reform efforts by the health care sector have largely failed to move away from the broken economic incentives of FFS.[24] Across the nation, the vast majority of payment arrangements continue to be anchored in broken FFS economics, with less than 8% of all health care services flowing through truly redesigned, non-FFS incentives that drive toward better care, lower costs and healthier patients (discussed in detail below).[25,26] This includes all forms of major health insurance as FFS provider payments are the predominant payment model in Medicare Advantage, Medicaid managed care, private health insurance, and traditional Medicare and Medicaid.[27] Most of the health care sector's claims about engaging in value-based payments are exaggerated and misleading.

Across the nation, the vast majority of payment arrangements continue to be anchored in broken FFS economics, with less than 8% of all health care services flowing through truly redesigned, non-FFS incentives that drive toward better care, lower costs and healthier patients.

The Majority of Payment Arrangements Are Still Based on Broken Fee-for-Service (FFS) Economics



Source: Health Care Payment and Learning Action Network (HCPLAN), APM Measurement, https://hcp-lan.org/apm-measurement-effort/2022-apm/.

The broken promise of payment reform

While health care executives publicly support payment reform and the shift to value-based health care, they privately express concerns about the potential loss of revenue they may experience from shifting out of the FFS payment model toward a new payment model that holds health care providers accountable for health outcomes and costs.[28] The result is that many health care executives are slow to engage in payment reform or do not engage at all, thereby preserving the status quo in U.S. health care — that is, FFS economics and a health care system that prioritizes the business interests of the health care sector at the expense of the health and financial security of families.[29]

To the extent there has been major activity from the health care sector in the name of payment and delivery reform over the last decade, it has been focused on vertical and horizontal consolidation, which destroys competition, weakens quality of care and drives higher prices under FFS economics.[30] For example, Aetna and Humana promoted payment reform goals as a key focus of their 2015 merger, claiming that the merger would provide Aetna with enhanced ability to work with providers and create value-based payment agreements resulting in better care to consumers.[31] They then abandoned the merger after the federal government successfully challenged it as an illegal monopoly.[32]

The University of Pittsburgh Medical Center, operating a dominant system in one of the country's most concentrated health care markets, also touted its achievements in payment reform.[33,34] However, UPMC financial records from 2022 suggest that the system has yet to make a meaningful transition away from FFS payment.[35] While these FFS prices continue to increase, bolstering UPMC's operating margins to record levels, there continues to be no accountability in the FFS payment system that these higher prices will result in improved health outcomes.[36,37]

In 2019, Mass General Brigham health system announced its current branding would focus on "a value-based model that delivers affordable primary care, secondary care and behavioral health in the community," ostensibly making patient-centered programs and services central to delivering better outcomes for its patients.[38] Three years later, the system was placed on a performance improvement plan by the Massachusetts Health Policy Commission due to its outsized contributions to unsustainable cost growth in the state.[39]

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The ability of the health sector to continue generating margins or profits based on FFS economics and monopolistic pricing under the guise of payment reform has resulted in only modest changes in moving the health care sector toward true value, changes that have mostly been insufficient to deliver on the promise of affordable, quality care.[40] Meanwhile, increases in health care industry consolidation have enabled many providers to leverage high commercial FFS rates and gain "must-have" status for insurance networks in a particular health care market.[41] These market dynamics not only increase the differential between Medicare and commercial insurance prices, but also reduce providers' enthusiasm to move toward value-based payment approaches and away from the easy profits of medical monopolies, price gouging and churning on FFS.[42]

Despite the patina of payment reform, our health care system continues to be deeply rooted in broken FFS provider payments.[43] In 2020, 97% of physicians relied on FFS and/or salary for compensation.[44] Most claims of value-based payment are actually pay-for-performance (P4P) payment models that only slightly modify FFS models.[45] These types of payment arrangements start with a FFS base and then typically tie bonus or penalty payments to clinical process measures rather than health outcome measures. Consequently, many P4P programs do little to nothing to reorient financial incentives away from FFS and produce mixed results on improving care quality or affordability, despite claims about value.[46,47] In addition, several studies have shown that P4P actually reduces access to care for socioeconomically disadvantaged populations because it incentivizes providers to avoid treating low-income patients who may have unique barriers to achieving improvements in their health.[48]

With the vast majority of health care services still flowing through FFS economics, it is unsurprising that health care payment and delivery reform efforts have not realized their potential to transform the way the health care system pays for and delivers health care, and to improve health, deliver affordable and quality care, and bend the cost curve.

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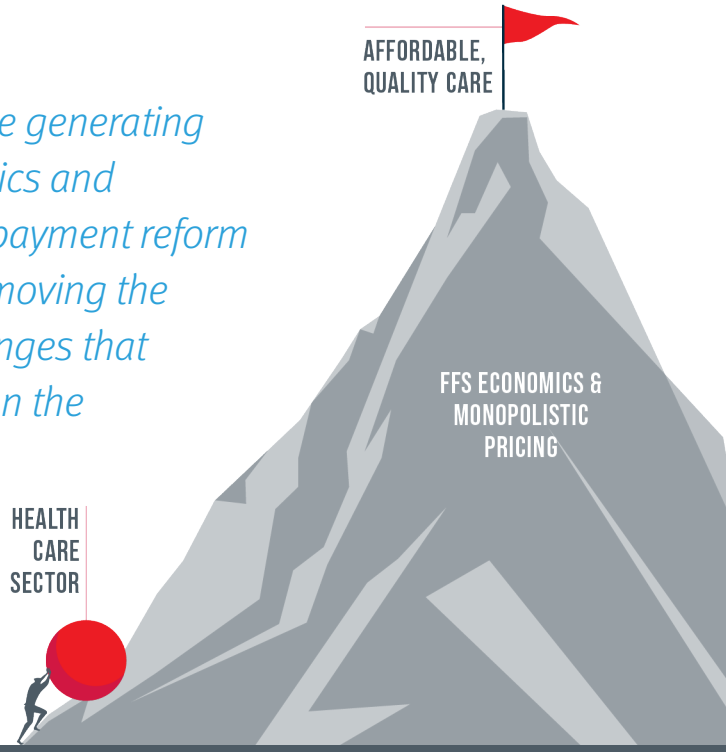

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The real promise of payment reform

Real payment reform, which is not based on FFS payment models, does hold the promise of effectively addressing broken incentives and can ensure our nation's families have affordable, quality care and the economic security they deserve.[49] If done intentionally and strategically, payment reform could serve as a critical tool to refocus our health care sector on addressing long-standing health disparities.[50]

The ability of payment reform to fulfill its promise hinges on moving away from FFS economics and creating new financial incentives that reward health care providers for keeping patients healthy and for addressing illness effectively and without waste and price gouging.[51] To make this transformation, the economics of the health sector's business model must be inverted to enable the sector to generate revenue by keeping people healthy and ensuring health care is affordable, rather than by billing for unnecessary visits and procedures and engaging in anti-competitive behavior and price gouging.[52] The key ingredient to successful payment reform is making it economically in the best interest of health care providers to address whole-person health needs. In other words, there must be a viable business model for providers to make the switch to non-FFS payment models, such as population-based payments, which hold providers accountable for health outcomes and the total cost of patient care.

Population-based payment models are based on paying one health care provider — typically a primary care organization or a health system — a single monthly payment, out of which the organization then pays for some or most health care costs for a whole population. Such payment arrangements are coupled with strong quality and outcome metrics to ensure that as providers' economics change, patients' health is thriving.

In this way providers are "at risk" for care that is wasteful and does not improve or protect patients' health. Providers make money when they are efficient and improve or protect patients' health, and they lose money if they are being wasteful or provide poor-quality care. This model, therefore, is structured

Population-Based Payment Models Incentivize Well-Coordinated, High-Quality and Person-Centered Care by:

Paying providers when they are efficient and improve or protect patients' health.

Covering a wide range of services, including preventive health care, care coordination, wellness services and services that address the social determinants of health, as well as standard medical procedures and services.

Not paying providers when they are being wasteful or provide poor-quality care.

to incentivize providers to deliver well-coordinated, high-quality, person-centered care. And the payments can be used to cover a wide range of services, including preventive health care, care coordination, wellness services and services that address the social determinants of health, as well as standard medical procedures and services.[53]

Importantly, these types of payment systems have a much greater impact if most insurers that contract with an organization, including public and private payers, are aligned. Such alignment unifies the organization's economics around population health and allows for real transformation of the way health care is organized and delivered.[54] Without this financial alignment, FFS economics will dominate and incentivize high-margin and high-profit procedures, instead of what is best for patients' health.

One critical variable in the success or failure of payment reform is understanding and accounting for the impact of marginalized and medically complex patients on providers' efforts to make money through effective population health management.[55] Risk adjustment is often used to reduce the incentive to avoid high-cost patients by ensuring clinicians are fairly compared with one another based on the quality of care they provide rather than quality measures or cost scores that vary because providers treat healthier or sicker patients.[56] It is critical to prioritize marginalized populations in payment reform by collecting, measuring and reporting on outcome measures with a comprehensive set of sociodemographic factors, and to overweight related quality metrics to incentivize providers to financially invest in solving health problems for these populations.[57]

Payment reform must allow for flexibility in how funding is spent to effectively address the social determinants of health, and those efforts must be tightly linked to clear population health and cost reduction targets to ensure the delivery of high-value health care services. Without such safeguards, payment reform could make inequities worse because traditional provider groups and hospitals will actively attempt to avoid treating patients with nonstandard needs, like housing insecurity, unmet behavioral health needs or even different cultural needs because those needs require different approaches and resources.[58]

Examples of authentic health care transformation

While considerable work remains to move the health care sector's value-based payment efforts toward true payment reform, there are several examples of health care payment transformation efforts that are making real progress toward improving health and making health care more affordable. Those transformation efforts highlight key tenets of what a reformed health care system should include: comprehensive and robust primary care, the integration of behavioral health and primary care, bundled payments for maternity care and other evidence-based procedures. Below is a brief overview of select health care transformation efforts.

Comprehensive and robust primary care. Oak Street Health is a network of value-based primary care centers that serve 150,000 Medicare beneficiaries in more than 130 clinics across 20 states, with a mission of rebuilding health care to focus on quality care and moving away from volume-based, fee-for-service payment.[59] More than 90% of its clinics are located in medically underserved communities with an average household income of 100% to 300% of the federal poverty level.[60] The primary care provider launched in 2012 with backing from private investors, private equity and Humana, and became a publicly traded company in 2020.[61] At the core of the Oak Street Health business model is leveraging value-based payment to do health care delivery differently.

Under this model, Oak Street Health enters into full-risk contracts with Medicare Advantage plans and assumes full financial risk for its patients in exchange for a fixed, per member, per month payment. Oak Street Health also participates in the Centers for Medicare & Medicaid Services' Medicare Shared Savings Program and Direct Contracting Accountable Care Organization model,* in which it is paid a flat fee to cover the medical expenses of its patients who are in the traditional Medicare program.[62] By taking full financial risk for its patient population, Oak Street Health's ability to generate revenue is directly tied to its ability to effectively manage and improve the health of the patients it serves. Importantly, the

* The Centers for Medicare & Medicaid Services redesigned the Global and Professional Direct Contracting (GPDC) model in response to administration priorities to signal commitment to advancing health equity, stakeholder feedback and participant experience. The model was renamed to the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. Current participants in the GPDC model must maintain strong compliance and agree to adhere to ACO REACH model requirements by January 1, 2023, to continue participating in the ACO REACH model.

Examples of authentic health care transformation, continued

primary care model has promising results: a 51% reduction in inpatient hospital admissions compared with national Medicare benchmarks, a 42% reduction in 30-day readmissions rates and a 51% reduction in emergency department visits for its patient population. The model also boasts important savings. In 2020, one of its accountable care organizations (ACOs) generated the fourth-highest savings rate of all ACOs, which resulted in $1,200 in annual taxpayer savings per Medicare beneficiary for the 5,000 patients served by this ACO.[63]

Behavioral health integration. The Vermont All-Payer Accountable Care Organization Model agreement was signed on October 26, 2016, by Vermont's governor, secretary of the Agency of Human Services, chair of the Green Mountain Care Board, and the Centers for Medicare & Medicaid Services. The all-payer model aims to reduce health care cost by moving away from FFS to risk-based arrangements for accountable care organizations, and to improve the health of Vermonters by achieving specific quality and health outcomes measures.[64] Specifically, the goal of the model is to increase access to primary care, reduce deaths from suicide and drug overdoses, and lower the prevalence of chronic disease. The model includes a statewide patient-centered medical home, community health teams, a "hub-and-spoke" system, and several programs focused on addressing the social determinants of health. Vermont's evidence-based hub-and-spoke model expands capacity for substance use disorder treatment and administers medication-assisted treatment.[65] The model includes nine regional "hubs" that offer daily support for patients with complex addictions and 75 local "spokes" that offer fully integrated behavioral health and primary care services.[66] In the first two performance years of the model (2018 and 2019), the model produced significant gross spending reductions in total Medicare parts A and B, reducing Medicare spending by $127.52 million overall, a 6.8% decrease. The model also reduced acute care stays by nearly 17% in the ACO and 9.3% statewide, and reduced 30-day readmission rates by 12.4% in the ACO and 22.4% across the state.[67,68]

Bundled payments for maternity care. Geisinger Health System is an integrated health care delivery system serving nearly 3 million people in rural central and northeastern Pennsylvania through three hospitals and more than 50 clinical sites, as well as Geisinger Health Plan, which provides health insurance for more than

Examples of authentic health care transformation, continued

200,000 people.[69] In 2007, Geisinger Health developed a bundled payment initiative to address rising rates of cesarean sections, incidences of medically unnecessary labor inductions and variations in care delivery leading to poor maternal health outcomes. The bundled payment provides a fixed payment rate for all prenatal, labor and delivery, and postpartum care delivery and was implemented across 22 clinical sites to redesign and standardize care delivery.[70] The model used 103 evidence-based best practice measures to track patient outcomes across the duration of their care and saw reductions in neonatal intensive care admissions, reductions in elective C-sections and medically unnecessary labor inductions, and increases in the rates of screening and smoking cessation interventions.

Bundled payments used for the comprehensive treatment of specific conditions — such as cancer care where providers are held accountable for the total cost and quality of care for a patient rather than only chemotherapy payments — offer real promise for reducing costs and improving outcomes by certain providers managing chronic conditions for their patient population.[71]

Bundled payment models by definition shift away from smaller FFS units of care to larger "episodes" of care (for example, 60, 90 or 180 days). Bundled payments create financial incentives for providers to enhance care coordination and increase efficiencies to improve health outcomes and lower costs during the episode. Bundles are an important step in moving toward higher-quality, more coordinated and less costly care. Importantly, bundles can result in pressure to increase the volume of services (that is, volume of bundles) being provided and do not hold providers accountable for outcomes outside of the window of the episode of care.[72] Thus, bundles can be used as a way to move provider organizations toward episodic care and on a path to true population-based payments, but bundled payments should not be the end goal.

Oregon's coordinated care organizations. In 2012, Oregon launched a coordinated care organization (CCO) program that is a regional Medicaid managed care program designed to be a single point of accountability for the health care access and quality of its Medicaid members.[73] Under the model, the Oregon Health Authority contracts with 15 coordinated care organizations across the state to provide integrated medical, behavioral and oral health care services to the state's Medicaid members using Section 1115 Medicaid waiver authority. Under this program, CCOs

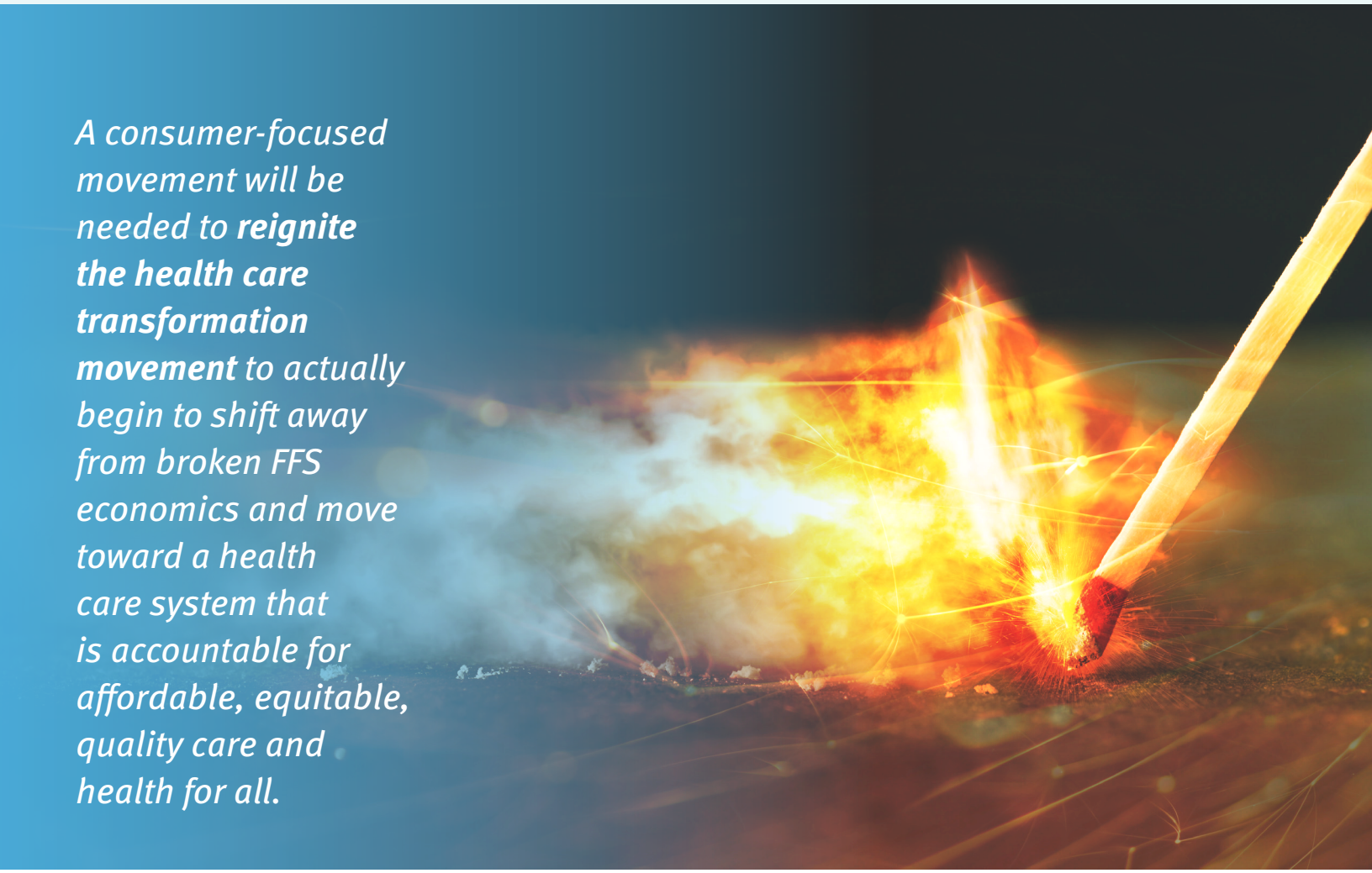
Examples of authentic health care transformation, continued

receive a global budget that covers physical, behavioral and oral health care services, and are responsible for coordinating and integrating whole-person health care services across local providers and communities, including the flexibility to deliver services that address the social needs of their patient population. Additionally, CCOs are held accountable for care quality and the growth of health care costs across the state's Medicaid population.[74]

In 2019, the Oregon Health Authority went through an extensive procurement process to secure the next iteration of CCOs, called CCO 2.0. Beginning in 2020, CCOs were required to make investments in "health-related services," including social determinants of health and health equity initiatives.[75] Oregon now directs CCOs to use administrative funds — that is, margins after paying for regular covered benefits — to provide services related to social determinants of health that fall outside traditional medical services. This includes food services and supports, including vouchers and meal delivery; housing services and supports, including temporary housing, utilities assistance and environmental remediation; and education services, including support for early childhood education, language, and literacy or high school graduation.[76] These health-related services are a formal component of CCO contracts.

Oregon also established the Social Determinants of Health and Health Equity Capacity-Building Bonus Fund to reward CCOs that reach social determinants of health milestones.[77] Results from the latest evaluation report of Oregon's CCO model indicate promising progress in achieving its goals, including a 10% decline in emergency department visits and a 17% decline in nontraumatic dental conditions from 2016 to 2019.[78] Additionally, the 2021 CCO financial report showed that the operating margins across the CCO system increased from 1.5% in 2020 to 2.1% in 2021, indicating the financial sustainability of the CCO model.[79]

To date, Oregon has succeeded in reducing the per member, per month Medicaid spending growth rate by 2 percentage points from a projected national average of 5.4% to 3.4%.[80] In 2021, Oregon expanded the model to apply a statewide health care cost growth target to all markets, capping annual per capita health care cost growth across the state to 3.4% for 2021-2025 and 3% for 2026-2030. In total, CCOs are projected to save $19 billion in Medicaid, Medicare and commercial health care costs over the next seven years.[81]



Conclusion

Health care transformation that is driven by fundamentally redesigning the economic incentives in the health care sector is essential for improving health and delivering on the promise of affordable, equitable and high-quality health care for our nation's families. Unfortunately, efforts to drive toward payment reform and the transformation of the delivery system are largely stalled. An organized consumer movement must play an important role as a counterbalance to industry interests with policymakers in Congress, the administration and in state capitols as the industry has shown it will be focused on preserving status quo business interests of the health care sector. A consumer-focused movement will be needed to reignite the health care transformation movement to actually begin to shift away from broken FFS economics and move towards a health care system that is accountable for affordable, equitable, quality care and health for all.

Endnotes

[1] David I. Auerbach and Arthur L. Kellerman, "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family," *Health Affairs* 30, no. 9 (September 2011): 1620–1636, https://www.rand.org/pubs/external_publications/EP201100172.html.

[2] Naomi N. Levey, "100 Million People in America Are Saddled with Health Care Debt," *Kaiser Health News*, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.

[3] Jared Ortaliza et al., "How Does U.S. Life Expectancy Compare to Other Countries?" Peterson-KFF Health System Tracker, September 28, 2021, https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/.

[4] Rabah Kamal, Julie Hudman, and Daniel McDermott, "What Do We Know About Infant Mortality in the U.S. and Comparable Countries?" Peterson-KFF Health System Tracker, October 18, 2019, https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries.

[5] "Healthcare-Associated Infections (HAIs)," Centers for Disease Control and Prevention, last reviewed October 27, 2021, https://www.cdc.gov/hai/data/portal/index.html.

[6] "Racism and Health," Centers for Disease Control and Prevention, last reviewed November 24, 2021, https://www.cdc.gov/healthequity/racism-disparities/index.html.

[7] *Americans' Views on Healthcare Costs, Coverage and Policy* (Chicago: NORC at the University of Chicago, n.d.), http://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Topline.pdf.

[8] Jason Urbaniec, "Top 10 Highest Paid CEOs at Nonprofits 2021," *ERI Blog*, Economic Research Institute, June 15, 2020, https://www.erieri.com/blog/post/top-10-highest-paid-ceos-at-nonprofits-2021.

[9] Levey, "100 Million."

[10] "NHE Fact Sheet," CMS.gov, U.S. Centers for Medicare & Medicaid Services, last modified August 12, 2022, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

[11] "Average Family Premiums Rose 4% This Year to Top $22,000; Employers Boost Mental Health and Telemedicine Amid COVID-19 Pandemic, Benchmark KFF Survey Finds," Kaiser Family Foundation, November 10, 2021, https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-this-year-to-top-22000/.

[12] Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of States* (Washington, DC: Urban Institute, January 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.

[13] Emily Sokol, "Healthcare Reimbursement Still Largely Fee-for-Service Driven," RevCycle Intelligence, March 26, 2020, https://revcycleintelligence.com/news/healthcare-reimbursement-still-largely-fee-for-service-driven.

[14] Health Care Payment Learning & Action Network, *Alternative Payment Model APM Framework* (MITRE Corporation, 2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

[15] Samuel H. Zuvekas and Joel W. Cohen, "Fee-for-Service, While Much Maligned, Remains the Dominant Payment Method for Physician Visits," *Health Affairs* 35, no. 3 (March 2016): 411–414, https://doi.org/10.1377/hlthaff.2015.1291.

[16] MedPac June 2018 Report to Congress: Medicare and the Health Care Delivery System, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.

[17] Heather Lyu et al., "Overtreatment in the United States," PLOS ONE, September 6, 2017, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970#pone.0181970.

[18] Lyu et al., "Overtreatment."

[19] Sanne Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," *NAM Perspectives*, Discussion Paper, National Academy of Medicine, October 9, 2017, https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

[20] Magnan, "Social Determinants of Health."

[21] "MACRA Payment Reforms Are Making a Difference," Energy and Commerce Committee Republicans, July 20, 2020, https://republicans-energycommerce.house.gov/news/macra-payment-reforms-are-making-a-difference/.

[22] Robert King, "Providers Push Congress to Include Value-Based Care Bill in $3.5T Infrastructure Package," Fierce Healthcare, August 25, 2021, https://www.fiercehealthcare.com/payer/providers-push-congress-to-include-value-based-care-bill-3-5t-infrastructure-package.

[23] Nona Tepper, "Signify, Caravan's $250 Million Deal Could Create Largest Network of Value-Based Providers," Modern Healthcare, February 22, 2022, https://www.modernhealthcare.com/mergers-acquisitions/signify-caravans-250-million-deal-could-create-largest-network-value-based.

[24] Hoangmai H. Pham and Amol S. Navathe, "Why Aren't Value-Based Payment Models More Successful? A Failure to Confront Market Dynamics," *Health Affairs Forefront*, January 27, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220125.362333/.

[25] Health Care Payment Learning & Action Network (HCPLAN), *APM Measurement: Progress of Alternative Payment Models: 2020-2021 Methodology and Results Report* (McLean, VA: MITRE Corporation, 2021), http://hcp-lan.org/workproducts/APM-Methodology-2020-2021.pdf.

[26] HCPLAN, *APM Measurement.*

[27] HCPLAN, *APM Measurement.*

[28] Ilene MacDonald, "Shift From Fee-for-Service to Value-Based Models Slower Than Expected," Fierce Healthcare, September 30, 2015, https://www.fiercehealthcare.com/finance/shift-from-fee-for-service-to-value-based-models-slower-than-expected.

[29] MacDonald, "Slower Than Expected."

[30] Jacqueline LaPointe, "Care Integration Driving Healthcare Mergers and Acquisitions," RevCycle Intelligence, August 3, 2013, https://revcycleintelligence.com/news/care-integration-driving-healthcare-mergers-and-acquisitions.

[31] Aetna, "Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care," news release, July 3, 2015, https://www.businesswire.com/news/home/20150702005935/en/Aetna-to-Acquire-Humana-for-37-Billion-Combined-Entity-to-Drive-Consumer-Focused-High-Value-Health-Care.

[32] Caroline Humer and Diane Bartz, "Aetna, Humana Drop Merger; Cigna Wants to End Anthem Deal," Reuters, February 14, 2017, https://www.reuters.com/article/us-humana-m-a-aetna/aetna-humana-drop-merger-cigna-wants-to-end-anthem-deal-idUSKBN15T1HN.

[33] Berenson et al., *Market Consolidation and High Prices.*

[34] "About Us," UPMC Center for High-Value Health Care, accessed October 15, 2022, https://www.upmchighvaluehealthcare.com/about_us.html.

[35] *UPMC Unaudited Financial and Operating Report, for the Period Ended June 30, 2022* (Pittsburgh, PA: University of Pittsburgh Medical Center (UPMC), June 2022), https://cdn.upmc.com/-/media/upmc/about/finances/documents/cy2022-q2-financial-and-operating-report.pdf?la=en&rev=73a08b69b8b94e268248a9afc48b0a30&hash=6BDBFE18AE8DF83131796AC940578768&_ga=2.183983910.1010383806.1661357762-2131927633.1661357761..

[36] Robert King, "UPMC Posts $605M Profit in First Half of 2021 as Insurance Business Dips," Fierce Healthcare, August 27,

2021, https://www.fiercehealthcare.com/hospitals/upmc-posts-605m-profit-first-half-2021-as-insurance-business-dips.

[37] Christopher M. Whaley et al., *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative* (Santa Monica, CA: Rand Corporation, 2020), https://www.rand.org/pubs/research_reports/RR4394.html.

[38] "Partners HealthCare Announces Five-Year Strategic Plan and Launch of System Rebranding," Mass General Brigham, November 27, 2019, https://www.massgeneralbrigham.org/en/about/newsroom/press-releases/partners-healthcare-announces-five-year-strategic-plan-and-launch-system.

[39] Massachusetts Health Policy Commission, "HPC Finds Mass General Brigham Cost Trends and Expansions Threaten State Health Care Affordability Efforts," Mass.gov, press release, January 25, 2022, https://www.mass.gov/news/hpc-finds-mass-general-brigham-cost-trends-and-expansions-threaten-state-health-care-affordability-efforts.

[40] Pham and Navathe, "Value-Based Payment Models."

[41] Pham and Navathe, "Value-Based Payment Models."

[42] Pham and Navathe, "Value-Based Payment Models."

[43] Suhas Gondi and Dave A. Chokshi, "Financial Stability as a Goal of Payment Reform – A Lesson From COVID-19," *JAMA* 324, no. 16 (2020): 1596–1597, https://jamanetwork.com/journals/jama/fullarticle/2772262.

[44] Mark J. Bethke et al., "Equipping Physicians for Value-Based Care: What Needs to Change in Care Models, Compensation, and Decision-Making Tools?" Deloitte, October 15, 2020, https://www2.deloitte.com/us/en/insights/industry/health-care/physicians-guide-value-based-care-trends.html.

[45] Health Care Payment Learning & Action Network (HCPLAN), *Alternate Payment Model: APM Framework: Refreshed for 2017* (MITRE Corporation, 2017), https://hcp-lan.org/apm-framework/.

[46] Cheryl L. Damberg et al., "Measuring Success in Health Care Value-Based Purchasing Programs: Findings From an Environmental Scan, Literature Review, and Expert Panel Discussions," *Rand Health Quarterly* 4, no. 3 (2014), https://www.rand.org/pubs/periodicals/health-quarterly/issues/v4/n3/09.html.

[47] Brittney A. Frankel and Tara F. Bishop, "A Cross-Sectional Assessment of the Quality of Physician Quality Reporting System Measures," *Journal of General Internal Medicine* 31, no. 8 (2016): 840–845, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4945566/.

[48] "What Is Pay for Performance in Healthcare?" *NEJM Catalyst*, March 1, 2018, https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245.

[49] Mark B. McClellan et al., "Payment Reform for Better Value and Medical Innovation," *NAM Perspectives*, Discussion Paper, National Academy of Medicine, March 17, 2017, https://nam.edu/payment-reform-for-better-value-and-medical-innovation/.

[50] Rachel H. DeMeester et al., "Solving Disparities Through Payment and Delivery System Reform: A Program to Achieve Health Equity," *Health Affairs* 36, no. 6 (June 2017): 1133–1139, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0979.

[51] Bobbi Brown and Jared Crapo, *The Key to Transitioning From Fee-for-Service to Value-Based Reimbursement* (Salt Lake City, UT: Health Catalyst, 2017), https://www.healthcatalyst.com/wp-content/uploads/2021/05/The-Key-to-Transitioning-from-Fee-for-Service-to-Value-Based-Reimbursement.pdf.

[52] J. Michael McWilliams, Alice Chen, and Michael E. Chernew, "From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments," Brookings, October 13, 2021, https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/.

[53] HCPLAN, *Alternate Payment Model*.

[54] *Promote Adoption of Population-Based Provider Payment: Cost Driver Targeted: Global Spending* (The Commonwealth Fund, February 2022), https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_02_population.pdf.

[55] Hannah Crook et al., *How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps* (Durham, NC: Duke University Margolis Center for Health Policy, February 2021), https://healthpolicy.duke.edu/sites/default/files/2021-02/How%20Are%20Payment%20Reforms%20Addressing%20Social%20Determinants%20of%20Health.pdf.

[56] Crook, et al., *Social Determinants of Health*.

[57] Crook, et al., *Social Determinants of Health*.

[58] Amol S. Navathe and Joshua M. Liao, "Aligning Value-Based Payments With Health Equity: A Framework for Reforming Payment Reforms," *JAMA* 328, no. 10 (2022): 925–926, https://jamanetwork.com/journals/jama/article-abstract/2795498.

[59] Oak Street Health, "Oak Street Health Releases Inaugural Social Impact Report," new release, March 30, 2022, https://investors.oakstreethealth.com/news/news-details/2022/Oak-Street-Health-Releases-Inaugural-Social-Impact-Report/default.aspx

[60] Oak Street Health, "Oak Street Health Releases."

[61] Tina Reed, "Oak Street Health Goes Public With $328M Offering," Fierce Healthcare, August 6, 2020, https://www.fiercehealthcare.com/practices/oak-street-health-goes-public-328-million-offering.

[62] Rebecca Pifer, "Oak Street to Enter 21st State With Launch of Colorado Clinics," Healthcare Dive, June 7, 2022, https://www.healthcaredive.com/news/oak-street-enter-21st-state-with-launch-colorado-clinics/625036/.

[63] Oak Street Health, "Social Impact Report."

[64] "About the Blueprint," State of Vermont Blueprint for Health, accessed October 15, 2022, https://blueprintforhealth.vermont.gov/about-blueprint.

[65] "Hub and Spoke," State of Vermont Blueprint for Health, n.d., https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke.

[66] Vermont Blueprint for Health, "Hub and Spoke."

[67] Sai Loganathan, *First Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model* (Chicago: NORC at the University of Chicago, August 2021), https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report.

[68] "Vermont All-Payer Model: Evaluation of the First Two Performance Years: 2018-2019," Center for Medicare & Medicaid Innovation, n.d., https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-report-aag.

[69] Sarah Lally, *Transforming Maternity Care: A Bundled Payment Approach* (Integrated Healthcare Association, September 2013), https://www.iha.org/wp-content/uploads/2020/10/Issue-Brief-Transforming-Maternity-Care-A-Bundled-Payment-Approach.pdf.

[70] Lally, *Transforming Maternity Care*.

[71] HCPLAN, *Alternate Payment Model*.

[72] David Blumenthal and David Squires, "The Promise and Pitfalls of Bundled Payments," *To the Point* (blog), The Commonwealth Fund, September 7, 2016, https://www.commonwealthfund.org/blog/2016/promise-and-pitfalls-bundled-payments.

[73] "Coordinated Care Organizations (CCO)," Oregon Health Authority, accessed October 15, 2022, https://www.oregon.

gov/oha/HSD/OHP/Pages/Coordinated-Care-Organizations.aspx.

[74] *Health-Related Services Brief* (Oregon Health Authority, November 2021), https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf.

[75] Oregon Health Authority, *Health-Related Services*.

[76] Oregon Health Authority, *Health-Related Services*.

[77] Oregon Health Authority, *Health-Related Services*.

[78] "Oregon Health Authority Releases Interim Report for 2017-2022 Medicaid 1115 Waiver Renewal Cycle," Center for Health Systems Effectiveness, Oregon Health & Sciences University, February 14, 2022, https://www.ohsu.edu/center-for-health-systems-effectiveness/oregon-health-authority-releases-interim-report-2017-2022.

[79] Oregon Health Authority, "New Report Finds Oregon CCOs Were Financially Stable Last Year," press release, State of Reform, July 14, 2022, https://stateofreform.com/news/2022/07/oregon-ccos-were-financially-stable-in-2021/.

[80] *Focused Equity Investments* (Oregon Health Authority, October 2021), https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3786e_2.pdf.

[81] Oregon Health Authority, *Equity Investments*.

Our health care system has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills.

People First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low-quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high-quality care for all.

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